DEPARTMENT OF DEFENSE APPROPRIATIONS FOR FISCAL YEAR 2007

WEDNESDAY, MAY 3, 2006

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:05 a.m., in room SD–192, Dirksen Senate Office Building, Hon. Ted Stevens (chairman) presiding.

Present: Senator Stevens, Inouye, and Mikulski.

DEPARTMENT OF DEFENSE

MEDICAL HEALTH PROGRAMS

STATEMENT OF LIEUTENANT GENERAL KEVIN C. KILEY, M.D., SURGEON GENERAL, DEPARTMENT OF THE ARMY

OPENING STATEMENT OF SENATOR TED STEVENS

Senator STEVENS. Thank you very much for your appearance.

We want to welcome you to this hearing as we seek to review the Department of Defense medical programs. There are two panels scheduled today. First we will hear from the surgeon generals, followed by the chiefs of the nursing corps. Today, joining us from the Army, we have Lieutenant General Kevin Kiley, Vice Admiral Donald Arthur, from the Navy, and Lieutenant General Peach Taylor, representing the Air Force. It's nice to have you all back with us again.

The President's fiscal year 2007 request for the defense health program is $21 billion, an increase over the fiscal year 2006 request. The request provides for healthcare for 9.2 million beneficiaries and for the maintenance and operation of 70 inpatient facilities and 1,085 clinics.

Our subcommittee recognizes that the continuing efforts overseas in support of the global war on terror and the national disaster relief, along with rising costs for prescription drugs and related medical costs, will continue to strain the financial resources that are contained in the request of this year's budget, will place an increased demand on our medical service providers, both here and those deployed in combat. The subcommittee also understands that the Department of Defense request to implement several initiatives to help mitigate this growing cost are here before us, and we plan to work with the Department to find the best means possible to medicate this rapid growth in regard to the financial burdens that you face.

Senator Inouye and I are personally familiar with the value of military medicine. We're committed to working with you to address the many challenges you face. We certainly applaud your efforts, military medical people and the nurses that are deployed in harm's way. These men and women in uniform risk their lives in support of our Nation in the global war on terror, and also here at home, through the devastations such as Hurricane Katrina. They support the warfighter and this country in all aspects of the fight, and we certainly commend them for their leadership, compassion, and bravery.

I'm pleased to yield to my co-chairman.

STATEMENT OF SENATOR DANIEL K. INOUYE

Senator INOUYE. Well, thank you very much, Mr. Chairman. I want to join you in welcoming our witnesses. They're all veterans here, and it's always reassuring to have them back.

Our military healthcare system has been transforming in a wide array of areas during the past few years. These changes not only affect the military treatment facilities and private-sector care, but extend to the battlefield, as well. And we have seen considerable growth in the benefits provided to our servicemembers and their families. At the same time, the private sector and the military treatment facilities are altering their management practices and patient resources due to new TRICARE contracts. We continue to see high patient volume, which requires seamless coordination between in-theater treatment, military treatment facilities, private-sector care, family support and counseling. And let's not forget the Veterans Administration.

Continued improvement in battlefield protection and combat casualty care have enabled us to save thousands of lives.

We're also transforming our approach to treatment at home. The direction of care is changing from focusing on individual servicemembers to focusing on the individual and his or her family from the moment orders are received to the time treatment is no longer needed. While we are engaged in this transformation, the Department has also initiated budget cuts and personnel changes that could have longstanding implications in our ability to care for our servicemembers and their families. These changes and fiscal constraints are compounded by the chronic recruiting and retention challenges faced by each service. Shortfalls reside in various specialties, but of most concern are those critically important to our servicemembers serving in harm's way, and their families, who rely upon the quality of homecare.

We look forward to discussing these and many issues crucial to the military medical system.

Once again, I'd like to thank the chairman for continuing to hold these hearings on issues which are so important to our military and their families. And I thank you very much.

Senator STEVENS. Thank you very much.

Our first witness will be Lieutenant General Kiley. We're going to place your full statements in the record as though read, and we'd like to hear the comments you wish us to hear.

General KILEY. Mr. Chairman, Senator Inouye, and distinguished members of the subcommittee, thank you for the oppor-

tunity to discuss the current posture of the Army Medical Department with you today.

During combat operations in Afghanistan and Iraq, we've recorded the highest casualty survivability rate in modern history. More than 90 percent of those wounded survive, and many return to the Army fully fit for continued service. Our investments in medical training, equipment, facilities, and research, which you have strongly supported, have paid tremendous dividends in terms of safeguarding soldiers from the medical threats of the modern battlefield, restoring their health and functionality to the maximum extent possible, and reassuring them that the health of their families is also secure. Military medicine is essential to Army readiness and an important quality-of-life program.

On any given day, more than 12,000 Army medics are deployed around the world supporting our Army in combat, participating in humanitarian assistance missions, and training not only at our centers throughout the world, but in Africa, South and Central America, and Eastern Europe.

In the past year, Army medics have cared for more than 6,000 soldiers evacuated from Iraq and Afghanistan, deployed in support of gulf coast hurricane relief operations, and deployed the Army's last mobile surgical hospital, the 212th, to support earthquake relief operations in Pakistan.

Over the past 3 years, more than half the Army medical, dental, and nurse corps officers have deployed at least once to Iraq or Afghanistan. Many of our critical wartime specialists have deployed multiple times. Every active component field hospital and forward surgical team has deployed multiple times. Our Reserve components, which comprise more than half the Army's medical force structure, have experienced similar operational tempo.

All of this is happening while we transform and reset the Army. 2005 base realignment and closure decisions, Army modular force decisions, and the integrated global positioning base strategy—basing strategy have presented us with a significant challenge and a significant opportunity to improve the way we care for patients in the battlefield and at our camps, posts, and stations around the world. This process is complicated by the long lead time necessary to plan and execute military construction and by the low thresholds for military construction projects.

In the short term, we continue to maintain high states of medical readiness and high service levels to families and retirees by increasing internal efficiencies, leveraging modular building technology, and relying on TRICARE networks, where necessary. Lean Six Sigma techniques are used throughout our planning process to develop expeditious, affordable solutions that ensure no decline in the accessibility or quality of the care provided to Army beneficiaries.

Much of the healthcare we provide to wounded soldiers is funded through supplemental appropriations. The military amputee care programs, centered at Walter Reed Army Medical Center and Brooke Army Medical Center, has cared for nearly 4,000—400—excuse me—amputees over the past 3 years. I want to thank Congress and the subcommittee for your continued support of this program. We're leading the Nation in improving amputee care and im-

proving the field of prosthetics technology. Working jointly with the Department of Veterans Affairs and the civilian industry, we're sharing lessons learned and raising the standards of amputee care across our country. Due to your support and advances in the care of amputees, many of these soldiers will be able to remain on active duty, and many will return to combat units fully capable of performing their duties.

Medical research, development, testing, and evaluation are critical to our ongoing success both on the battlefield and in our hospitals around the country. Over the past year, we've pulled 12 medical products out of the research, development, test and evaluation (RDT&E) process and fielded them to deploying forces because of their demonstrated efficacy and safety in improving patient care and force protection on the battlefield.

Despite all of our advances in battlefield medicine, hemorrhage continues to be the major cause of death on the battlefield, and we continue to develop and test blood substitutes and hemostatic agents to mitigate blood loss in our combat casualties.

Today, every soldier in Iraq and Afghanistan deploys with a hemostatic bandage and a tourniquet. Evacuation assets quickly move casualties from the battlefield to the forward surgical teams and combat support hospital within minutes of injury. These advances in equipment, training, and doctoring are saving lives every day in Iraq and Afghanistan.

To support homeland security, Fort Detrick, Maryland, is working to become the home of the National Interagency Biodefense Campus. This interagency initiative co-locates researchers from the Department of Defense, the Centers for Disease Control and Prevention (CDC), Department of Agriculture, Department of Homeland Security, and the National Institute of Allergy and Infectious Diseases to achieve productive, efficient, interagency cooperation in support of our Nation's biodefense.

Military health benefit has gained critical attention this year due to the Department's proposal to initiate control over the long-term costs and sustain this important benefit for our current and future retirees. This truly outstanding health benefit is important for accessions, retentions, and military readiness. Each service has taken action over the past few years to improve efficiencies and control healthcare costs. However, these actions alone will not stem the rising costs in the military health benefit.

I am concerned that delaying action will put even greater financial pressure on our hospitals and clinics, when we are still trying to care for combat casualties and continue to deploy Active and Reserve component soldiers.

The President's budget request adequately funds the defense health program to meet our military medical readiness requirements if the sustaining benefits proposals are enacted. However, the medical budgets of the three services have little flexibility to absorb additional efficiencies to sustain our medical readiness mission if no action is taken in this important issue.

In closing, let me emphasize that the service and sacrifice of our soldiers and their families cannot be measured with dollars and cents. The truth is, we owe far more than we can ever pay to those who have been wounded and to those who have suffered loss.

Thanks to your support, we've been very successful in developing a healthcare delivery system that honors the commitment of our soldiers, retirees, and their families that have been made to our Nation by providing them with world-class medical care and peerless military force protection.

PREPARED STATEMENT

Thank you, again, for inviting me to participate in the discussions today, and I look forward to answering your questions.

Senator STEVENS. Thank you, General.

[The statement follows:]

PREPARED STATEMENT OF LIEUTENANT GENERAL KEVIN C. KILEY, M.D.

Mr. Chairman, Senator Inouye, and distinguished members of the subcommittee, thank you for the opportunity to discuss the current posture of the Army Medical Department and our requirements for fiscal year 2007. During the past five years, military medicine has constantly exceeded any measure of success we could establish. During combat operations in Afghanistan and Iraq, we have recorded the highest casualty survivability rate in modern history. More than 90 percent of those wounded survive and many return to the Army fully fit for continued service. Our investments in medical training, equipment, facilities, and research, which you have strongly supported, have paid tremendous dividends in terms of safeguarding Soldiers from the medical threats of the modern battlefield, restoring their health and functionality to the maximum extent possible, reassuring them that the health of their families is also secure. Military medicine is essential to Army readiness and an important quality of life program.

On any given day more than 11,000 Army medics—physicians, dentists, veterinarians, nurses, allied health professionals, administrators, and combat medics—are deployed around the world supporting our Army in combat, participating in humanitarian assistance missions, and training not only at our training centers throughout the world but in Africa, South and Central America, and Eastern Europe. In the past year, Army medics have cared for more than 6,000 Soldiers evacuated from Iraq and Afghanistan; deployed a combat support hospital, a medical logistics company, and several preventive medicine and veterinary teams in support of Gulf Coast hurricane relief operations; and deployed the Army's 212th Mobile Army Surgical Hospital (MASH) to support earthquake relief operations in Pakistan.

The story of the 212th MASH illustrates the dedication, flexibility, and adaptability of Army Medicine. On September 23, 2005, the 212th returned to Germany after a 3-week training and humanitarian assistance mission in Angola. Within days of the devastating earthquake that struck Pakistan on October 8, the 212th MASH was on its way to provide surgical and medical care to survivors. When the Pakistani mission became apparent, the 212th was the only Department of Defense unit that could fill the requirement. It was close to Pakistan, mobile enough that it could be put in position quickly, and completely self-contained with the capability to house and feed its staff without additional assistance from support units or the host nation. The 212th returned to Germany in late-February and has begun training with new equipment for an upcoming deployment to Iraq.

It is this dedication, flexibility, and adaptability that has allowed us to provide superb medical care for more than 24,000 sick or injured Soldiers from Iraq and Afghanistan over the past three years. Army Medicine is an integrated system of healthcare designed, first and foremost, to protect and treat the warfighter. Let me explain how we accomplish this and several new initiatives underway to improve how we work.

RECRUITING AND RETENTION

Success begins with recruiting, training, and retaining quality healthcare professionals. Fiscal year 2005 presented recruitment challenges for healthcare providers. We made 99 percent of our goal for Medical Corps recruitment (goal of 419 with 416 achieved) and 84 percent of our Dental Corps goal (goal of 125 with 105 achieved). However, the Army fell short of its goals for awarding Health Professions Scholarships in both the Medical Corps (77 percent of available scholarships awarded) and Dental Corps (89 percent of scholarships awarded). These scholarships are by far the major source of accessions for physicians and dentists. This presents a long-term recruiting challenge beginning in fiscal year 2009. It is too early to tell

if this is a one-year anomaly or the beginning of a long-term trend, but we are working hard to ensure every available scholarship is awarded this year. In conjunction with United States Army Recruiting Command (USAREC) we have initiated several new outreach programs to improve awareness of these programs and to increase interest in a career in Army Medicine. I also ask for your support of legislation just submitted by DOD establishing a 2-year pilot program for an increased recruitment incentive bonus in up to five critical medical specialties. We hope this will attract more interest in our critical medical specialties.

In January I sent letters to the Deans of every U.S. medical school, asking for opportunities for Army physicians and Army recruiters to meet with medical students and discuss opportunities to serve in the Army. Response to date has been strong and positive. We will use the same tactic with dental and nursing schools this year.

I am encouraged by a recent analysis of retention among active duty Medical Corps officers in fiscal year 2005. More than 50 percent of physicians who completed their initial active duty service obligation last year agreed to stay for at least one more year. This analysis challenges the myth that increased operations tempo leads to lower retention. We continue to monitor this trend carefully and will be expanding the analysis to include dentists and nurses in the next year.

The Reserve Officer Training Corps (ROTC) is a primary source for our Nurse Corps Force. In recent years, ROTC has had challenges in meeting the required number of Nurse Corps accessions and as a consequence, USAREC has been asked to recruit a larger number of direct accession nurses to fill the gap. This has been difficult in an extremely competitive market. In fiscal year 2005, USAREC achieved 83 percent of its Nurse Corps mission. We have recently raised the dollar amount that we offer individuals who enter our Army Nurse Candidate Program to $5,000 per year for max of two years with a $1,000 per month stipend. Last year we increased the multi-year bonuses we offer to Certified Registered Nurse Anesthetists with emphasis on incentives for multi-year agreements. A year's worth of experience indicates that this increased bonus, 180-day deployments, and a revamped Professional Filler system to improve deployment equity is helping to retain CRNAs.

Reserve Component Accessions and Retention continue to be a challenge. In fiscal year 2005 we expanded accessions bonuses to field surgeons, social workers, clinical psychologists, all company grade nurses and veterinarians in the Army National Guard and Army Reserve. We also expanded the Health Professions Loan Repayment Program and the Specialized Training Assistance Program for these specialties. In February 2006, we introduced a Baccalaureate of Science in Nursing (BSN) stipend program to assist non-BSN nurses complete their four-year degree in nursing. This will be an effective accessions and retention tool for Reserve Component Nurses who have only completed a two-year associates degree in nursing. Working with the Chief of the Army Reserve and the Director of the Army National Guard, we continue to explore ways to improve Reserve Component accessions and retention for this important group. The Reserve Components provide over fifty percent of Army Medicine's force structure and we have relied heavily on these citizen Soldiers during the last three years. They have performed superbly.

INSTALLATIONS AS OUR FLAGSHIPS

Army healthcare providers train and maintain their clinical skills in hospitals and clinics at Army installations around the world everyday. Our medical treatment facilities are the centerpiece of medical readiness. These facilities provide day-to-day healthcare for Soldiers to ensure they are ready to deploy; allow providers to train and maintain clinical competency with a diverse patient population that includes Soldiers, retirees, and families; serve as medical force projection platforms, and provide resuscitative and recuperative healthcare for ill or injured Soldiers. In order to do this successfully, we must sustain appropriate workload and patient case-mix in our facilities and have a supportive network of civilian providers for the healthcare services we cannot effectively or efficiently provide.

The combination of Base Realignment and Closure (BRAC) decisions, Army Modular Force decisions, and the Integrated Global Positioning and Basing Strategy have presented us with a significant challenge and a significant opportunity to improve the way we care for patients at affected installations. This is complicated by the long-lead time necessary to plan and execute military construction and by low thresholds for military construction projects.

Two important proposals coming forward from the Quadrennial Defense Review will enhance our flexibility to rapidly implement military construction projects in response to the challenges of Army restationing initiatives. One increases the Operations & Maintenance threshold for military construction from the current cap of

$750,000 to $3,000,000. The second proposal increases the unspecified minor military construction threshold from $1,500,000 to $7,000,000—the same authority the Department of Veterans Affairs has. The Army fully supports these proposals. We need to have authority comparable to the Department of Veterans Affairs in order to reset our medical force in support of these restationing decisions.

Much of the healthcare we provide to wounded Soldiers is funded through supplemental appropriations. The Military Amputee Care Program, centered at Walter Reed Army Medical Center and Brooke Army Medical Center, has cared for nearly 400 amputees over the past three years. I want to thank the Congress and the subcommittee for your continued support. This program is leading the nation in improving amputee care and improving the field of prosthetics technology. They are working jointly with the Department of Veterans Affairs and civilian industry to share lessons learned and raise the standard of amputee care across our country. Due to your support and advances in the care of amputees, many of these Soldiers will be able to remain on active duty and many will return to combat units fully capable of performing their duties.

RESEARCH AND DEVELOPMENT

Medical Research, Development, Testing, and Evaluation are critical to our ongoing success both on the battlefield and in our hospitals around the country. Over the past year we have pulled 12 medical products out of the RDT&E process and fielded them to deployed forces because their demonstrated efficacy and safety in improving patient care and force protection on the battlefield. Despite all of our advances in battlefield medicine, hemorrhage continues to be the major cause of death on the battlefield. We continue to develop and test blood substitutes and hemostatic agents to mitigate blood loss in our combat casualties. Today, every Soldier in Iraq and Afghanistan deploys with a hemostatic bandage and a tourniquet. Evacuation assets quickly move casualties from the battlefield to Forward Surgical Teams and Combat Support Hospitals within minutes of injury. These advances in equipment, training, and doctrine are saving lives every day in Iraq and Afghanistan.

Army scientists continue their work in research and development of new vaccines, including adenovirus vaccine, malaria vaccine, and plague vaccine. These vaccines are needed to protect against microbes that threaten Soldiers in basic training, in tropical locations, or as bioweapons. To support Homeland Security, Fort Detrick, Maryland has become the home for a National Interagency Biodefense Campus (NIBC). This interagency initiative collocates researchers from Department of Defense, Centers for Disease Control, Department of Agriculture, Department of Homeland Security and the National Institutes for Allergy and Infectious Diseases to achieve productive and efficient interagency cooperation in support of our Nation's biodefense.

A key component of protecting Soldiers on the battlefield and citizens at home from the threat of chemical and biological agents is research and development of medical countermeasures against such agents. The infrastructure and expertise to do this resides within the U.S. Army Medical Research and Materiel Command (USAMRMC) at Fort Detrick, Maryland. The U.S. Army Medical Research Institute for Infectious Diseases (USAMRIID) at Fort Detrick, and the U.S. Army Medical Research Institute for Chemical Defense (USAMRICD) at Aberdeen Proving Ground, Maryland, represent critical national capabilities that, in addition to National Defense, support the entire spectrum of Homeland Security.

USAMRIID provides basic and applied research on biological threats resulting in medical solutions to protect the War Fighter and offers a comprehensive ability to respond to biological threats. USAMRIID scientists have more than 34 years of experience safely handling the world's deadliest pathogens in biocontainment. USAMRICD is charged with the development, testing, and evaluation of medical treatments and materiel to prevent and treat casualties of chemical warfare agents. In addition to research, USMRICD, in partnership with USAMRIID, educates health care providers in the medical management of chemical and biological agent casualties. Simply put the Nation's experts in chemical and biological weapons work at USAMRIID and USAMRICD.

SUSTAIN THE BENEFIT

The Army requires a robust military medical system to meet the medical readiness needs of active duty service members in both war and peace, and to train and sustain the skills of our uniformed physicians, nurses, and combat medics as they care for family members, retirees, and retiree family members. Therefore we share the Department of Defense's (DOD) concern that the explosive growth in our

healthcare costs jeopardizes our resources, not only to the military health system but in other operational areas as well.

Expansion of TRICARE to the Selected Reserve in the fiscal year 2005 and fiscal year 2006 National Defense Authorization Act highlights the challenge presented to DOD by expanding benefits with limited resources. We are very concerned by the projections of cost growth in the Defense Health Program over the next ten years. Without addressing the issues, our healthcare costs will total approximately 12 percent of the DOD budget by 2015. This growth forces us to look for additional efficiencies in our direct care system and threatens quality of life, readiness, and modernization programs.

The Army and Army Medical Command fully support the Sustaining the Benefit proposals for working age retirees, as it represents a reasonable approach to meeting the challenge of providing for our Soldiers and the future of our force. After the proposal is fully implemented, TRICARE will still remain a very affordable option for our military retirees under the age of 65, with out-of-pocket costs for retirees still projected to be little more than half of the costs for members of the Federal Employee Health Benefits Program. The change merely begins to bring the cost share for working age military retirees in line with the same proportion it was when Congress created TRICARE.

The Department of Defense continues to explore other opportunities to help control costs within the Defense Health Program and in many of initiatives the Army leads the Department in implementation and innovation. This year, I implemented a performance-based budget adjustment model throughout the Army Medical Command. This model accounts for provider availability, proper coding of medical records, and use of Clinical Practice Guidelines to adjust hospital and clinic funding levels to reflect the cost of actual healthcare delivered. The Southeast Regional Medical Command implemented this system in 2005 where it increased staff awareness on properly documenting workload and staff availability. This model increases command attention to the business of delivering healthcare. It is an Internet-based model so commanders at all levels receive fast feedback on their organization's performance. Finally, use of Clinical Practice Guidelines encourages efficiency by using nationally accepted models for disease management. These adjustments provide my regional commanders the flexibility needed to move funds within their region to the facilities that are demonstrating improved performance and the ability to absorb more care from TRICARE networks.

The Army is also leading the Department's implementation of an electronic medical record. The armed forces health longitudinal technology application (AHLTA) will help to significantly reduce the number of negative medical outcomes and errors compared to paper methods of documenting treatment and ordering drugs. Eighty-three percent of Army hospitals are using AHLTA today and every Army hospital will be using AHLTA by the end of August 2006. Nearly two-thirds of Army hospitals have fully implemented AHLTA and the Army leads DOD in the number of healthcare providers using AHLTA. For the past 3 years, Army providers deployed in Iraq and Afghanistan have been using the Theater Medical Information Program so each Soldier's treatment data is available to providers at Landstuhl, Walter Reed, or other Army medical treatment facilities when that Soldier-patient comes home. The Army Medical Department now captures over 200,000 patient encounters a week in this 21st century medical record.

The 2005 Base Realignment and Closure decisions demonstrate actions to improve the joint delivery of healthcare in both the National Capital Area and San Antonio, Texas. Recommendations to collocate medical training for all three Services at Fort Sam Houston, Texas and to collocate a number of medical research and development activities at Fort Detrick allows for enhanced synergy, collaboration and cost effectiveness. The next step is to move beyond a collocation of these activities to implementation of a business plan that realizes a true integration of DOD's medical training and research activities.

The Army continues to support the development of a Unified Medical Command and is working closely with our sister Services and the Joint Staff to realize the full potential of this initiative. A fully functional unified command represents an opportunity to reduce multiple management layers within DOD's medical structure, inspire collaboration in medical training and research, and gain true efficiencies in healthcare delivery. These changes need to be made in conjunction with actions to Sustain the Benefit.

In closing let me emphasize that the service and sacrifice of our Soldiers—and their families—cannot be measured with dollars and cents. The truth is that we owe far more than we can ever pay to those who have been wounded and to those who have suffered loss. Thanks to your support, we have been very successful in developing a healthcare delivery system that honors the commitment of our Soldiers, re-

tirees, and their families made to our Nation by providing them with world-class medical care and peerless military force protection.

Thank you again for inviting me to participate in this discussion today. I look forward to answering your questions.

Senator STEVENS. Admiral Arthur.

STATEMENT OF VICE ADMIRAL DONALD C. ARTHUR, M.D., SURGEON GENERAL, DEPARTMENT OF THE NAVY

Admiral ARTHUR. Good morning, Chairman Stevens and Ranking Member Inouye. Thank you very much for the opportunity to address the subcommittee.

In this age of interoperability of the three services, I dare say that each of the surgeons could have given the same opening comments. And, in that spirit, I echo what General Kiley has said in his opening remarks, they equally apply to Navy medicine.

We also have thousands of people deployed to Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF), where we're very proud of the greater than 90 percent survival rate for combat injuries, the lowest disease and nonbattle injury rate in history, and the rapid rate at which combat casualties can be taken from the field, resuscitated, brought to Landstuhl and then for further care at Walter Reed, Bethesda, Malcolm Grow, and other great facilities throughout the country.

We believe in family-centered care for these casualties, and we've continued the policy of having family members meet the casualties as they are received in our continental United States (CONUS) facilities. Most of the casualty care that we have delivered has been on the east coast, and we're proud to announce that this summer we'll open up a Comprehensive Combat Casualty Care Center in San Diego, where we will offer the full spectrum of rehabilitative services. I have asked that each member of the rehabilitate team have specific training in combat stress and the psychological effects of combat. I've also asked that this center be staffed by as many combat veterans, and especially combat-wounded sailors as possible to provide that degree of empathy for the combat-wounded.

We are also reshaping our force for future events, especially humanitarian assistance, stability operations, homeland defense, and disaster relief, which is not currently part of our planning for combat casualty care injuries. I think the important thing is that we need to have the flexibility to accomplish all of the missions that we might be tasked to join. A good example of our flexibility is the U.S.N.S. *Mercy*, which launched recently on a humanitarian assistance mission to Southeast Asia, where it will, in collaboration with nongovernmental organizations (NGO), deliver humanitarian services to many people who have been unreached by the United States in any other way. And I think that that will provide us with a great deal of diplomacy in those areas.

We are having challenges in recruiting and retention. I know that Senator Mikulski is interested in how we have used the loan repayment program. We are very proud that we have made some inroads in our recruiting efforts with these programs.

One of the issues which is most challenging for us is the operational tempo, as General Kiley talked about. We have some specialities, especially those that are combat intensive—surgeons, nurse anesthetists, operating room (OR) technicians—who have deployed

at least once, and sometimes two times, per year over the last 3 years.

The administration's proposals to manage cost growth and sustain this valuable TRICARE benefit encourages beneficiaries to elect medically appropriate, cost-effective healthcare options. The Navy supports the words of the Joint Chiefs, Chairman Pace and Secretary Rumsfeld, and wants to work closely with the distinguished members of this subcommittee and all of Congress to sustain this great health benefit.

I would like to mention one guest that we have with us today. That is Captain Catherine Wilson, who just returned from Kuwait as the commanding officer of the expeditionary medical force, so she's a nurse corps officer who is en route to Naval Hospital Bremerton, where she will be the commanding officer. And she's our officer with the most recent combat support experience. And she's with us today. I'm glad to have her here.

Senator STEVENS. Catherine, why don't you stand up so we can recognize you?

Admiral ARTHUR. Cathy.

Senator STEVENS. Thank you very much.

Admiral ARTHUR. One of the things that we have decided to do recently is to re-code all of our leadership billets to be corps-nonspecific, so that it could be—all leadership billets can be occupied by any corps in the Navy. And Captain Wilson is a good example, as a nurse corps officer, who went there and did an outstanding job in combat support.

PREPARED STATEMENT

Mr. Chairman, thank you very much for allowing me to give you some opening comments. And I look forward to all of your questions.

Thank you.

Senator STEVENS. Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF VICE ADMIRAL DONALD C. ARTHUR

INTRODUCTION

Chairman Stevens, Ranking Member Inouye, thank you for the opportunity to testify before you today about the state of Navy Medicine and our plans for the upcoming year.

Navy Medicine is an integral part of the Navy and Marine Corps team and plays a key role in our ever expanding and more diverse missions that continue to evolve as we fight the global war on terrorism. Against new enemies whose arsenals include catastrophic medical threats, Navy Medicine is a critical defensive weapon for the Navy and Marine Corps team. Consider just a few of these efforts: Navy Medicine provides surveillance for biological attacks, immunizes personnel to reduce the impact of bioterrorism events, assesses potential health threats in the operational environment, and provides expert clinical consultation to operational commanders, all while providing combat casualty care far-forward and exceptional care for our heroes and their families here at home.

FORCE HEALTH PROTECTION

The primary focus of Navy Medicine is Force Health Protection. Navy Medicine is preparing a healthy and fit force that can go anywhere and accomplish any mission that the defense of the nation requires. Further, Navy Medicine goes with them, to protect the men and women in uniform from the hazards of the battlefield.

But as hard as we try, all this preparation does not fully prevent the physical and psychological impact of combat service.

COMBAT CASUALTY CARE

As you know, more seriously injured warfighters are surviving their wounds—more than in any other conflict in history. These low mortality rates can be attributed to improved trauma and combat casualty care of our medical personnel, advances in medical technology, better body armor, and improved training of our medical personnel; however, one of the most important contributors to saving lives on the battlefield has always been, and remains Navy corpsmen—Navy Medicine's first responders on the battlefield. The platoon corpsmen are supported by a team of field surgeons, nurses, medical technicians and support personnel in theater, who are supported by medical evacuation teams and overseas Military Treatment Facilities (MTF) working together with MTFs in the United States—this is the Navy Medicine continuum of care.

Navy Medicine's commitment to the warfighter is clearly seen in the combat casualty care provided to injured and ill Marines and Sailors engaged in Operations IRAQI FREEDOM and ENDURING FREEDOM since the beginning of the Global War on Terror. Combat casualty care is a "continuum-of-care," which begins with corpsmen in the field with the Marines; progresses to forward resuscitative care; on to theater level care; and culminates in care provided in route during patient evacuation to a military hospital. Medical care is being provided in Iraq and Afghanistan by organic Marine Corps health services units which include battalion aid stations, shock trauma platoons, surgical companies, and Forward Resuscitative Surgical Systems.

During current operations, Navy Medicine has made significant advances in the health care provided by first responders and in access to resuscitative surgical care during the critical "golden hour." A badly injured Marine who receives advanced medical care within an hour of injury is highly likely to be saved.

Navy Medicine is also deployed worldwide with Naval air, surface and subsurface forces, providing daily health service support, force health protection, and medical intelligence and planning for the Navy's many traditional and nontraditional missions.

Our operationally-focused research efforts in areas such as disease surveillance, bioweapon detection, protection and countermeasures, emerging illnesses, field medical gear, and advanced aviation and diving physiology facilitates the warfighter's efforts to do his or her job more safely and effectively.

As our engagement in Iraq and Afghanistan continues, the number of injured service members who return in need of critical medical services will increase. As a result, and due to the severity and complexity of their injuries, increased cooperation and collaboration with our federal health care partners is essential to providing quality care. As an extension of Navy Medicine's ability to care for patients, partnerships with Veterans Affairs (VA) medical facilities continue to grow and develop into a mutually beneficial association. In 2003, the VA created the Seamless Transition Program to address the logistic and administrative barriers for active duty service members transitioning from military to VA-centered care. This program is working well and continues to improve as new lessons are learned. Recently-wounded Sailors and Marines differ from the VA's traditional rehabilitation patient in age, extent and complexity of injury, and family involvement; therefore, we are actively engaged at all levels to ensure that quality care is being provided throughout both systems.

PARTNERSHIP WITH THE DEPARTMENT OF VETERANS AFFAIRS

Navy Medicine and the Department of Veterans Affairs continue to pursue enhancements to information management and technology initiatives to significantly improve the secure sharing of appropriate health information. Several efforts are underway that will enable us to share real-time patient information and to improve system interoperability. We also continue to support the pursuit of increased sharing and are currently managing medical and dental agreements across the country.

In addition, our joint effort to create a hybrid organization based on new paradigms and practices continues to move forward. The Federal Health Care Facility at the site of Naval Hospital Great Lakes and the North Chicago Veterans Affairs Medical Center will operate under a single line of authority, overseen by a Board of Directors. All services currently being offered at both facilities will remain available, but will be delivered more efficiently within a seamless patient care and support environment.

Finally, in the area of military construction Navy Medicine is pursuing a variety of joint ventures that include a Consolidated Medical Clinic aboard the Naval Weap-

ons Station in Charleston, SC; a VA clinic to be built to replace the Naval Clinic at Corry Station in Pensacola, FL; and planned replacement hospitals at Beaufort and Guam, each of which will include a VA presence. We are also pursuing Joint Incentive Fund Projects, as directed by the fiscal year 2003 National Defense Authorization Act, across the enterprise.

MENTAL HEALTH

The issue of mental health has been receiving much deserved attention since the beginning of OEF/OIF. I would like to take this opportunity to share with you some of the things that the Department of the Navy is doing to help the Navy and Marine Corps team cope with the stresses of combat.

Anyone exposed to the extremely stressful environment of combat is affected by those events, with the effects varying with each individual service members. Although most cope with no significant or lasting impact, a small percentage will need assistance in dealing with their experiences, and some of them may ultimately be diagnosed and treated for Post Traumatic Stress Disease or other mental health conditions.

Marines and Sailors are prepared for the psychological rigors of combat by being run through a realistic recreation of combat during pre-deployment training. Health screenings are conduced via the multi-tiered deployment health assessment process, prior to deployment, immediately upon return from theater, and most recently at the 3–6 month post deployment mark. In theater, Sailors and Marines have prompt access to chaplains, medical officers, and other mental health providers embedded with the operation forces through the Operational Stress Control and Readiness (OSCAR) Program. All aircraft carriers have a psychologist attached to the medical department aboard ship, and many of our new expeditionary strike groups also deploy with psychologists or psychiatrists onboard. In addition, since reunifications can sometimes be difficult, Sailors and Marines returning home are prepared to reunite with their families and communities through the "Warrior Transition" and "Return and Reunion" programs.

DEPLOYMENTS AND QUALITY OF CARE

On an average day in 2005, Navy Medicine had over 3,500 medical personnel from the active and reserve components deployed in support of Operations, Exercises or Training around the world. Our missions vary and include humanitarian assistance abroad and at home; environmental risk assessments around the world; and combat casualty care.

Navy Medicine is continuously monitoring the impact deployments of medical personnel have on our ability to provide quality health care at home. Together with the network of TRICARE providers who support local Military Treatment Facilities (MTFs), beneficiaries have been able to continue accessing primary and specialty care providers. We closely monitor the access standards at our facilities using tools like the peer review process, to evaluate primary and specialty care access relative to the Department of Defense's standard.

Another means used to ensure quality is our robust quality assurance and risk management programs that promote, identify, and correct process or system issues and address provider and system competency issues in real time. Our program promotes a patient safety culture that complies with nationally established patient safety goals. These goals include training in the area of medical team management to improve communication processes as well as implementation of the Bureau of Medicine and Surgery (BUMED) advisory boards' recommendations in critical patient safety and quality areas, such as perinatal care.

We have established evidence-based medicine initiatives and currently measure diabetes, asthma and women's breast health. Soon, we will add dental health and obesity.

Navy Medicine also promotes healthy lifestyles through a variety of programs. These programs include: alcohol and drug abuse prevention, hypertension identification and control, tobacco use prevention and cessation, and nutrition and weight management. Partnering with other community services and line leadership enhances their effectiveness and avoids duplication.

CHANGES IN NAVY MEDICINE

Since I testified before you nearly a year ago, Navy Medicine has gone through several changes to meet the evolving needs of the Navy and Marine Corps team. Last summer, we implemented a focused enterprise wide realignment effort to better direct our assets to maintain readiness and deliver the highest quality care in the most cost effective manner. This effort included standing up four regional com-

mands—Navy Medicine West, Navy Medicine East, Navy Medicine National Capital Area and Navy Medicine Support Command—to provide a centralized and standardized structure of command and control. The regional commands have flexibility in supporting operational requirements while improving health care access and logistic support for all beneficiaries. Also, Navy Medicine's ten reserve medical units, Operational Health Support Units (OHSU), are aligned with the regional commands to gain operating efficiencies and maximizes the utilization of reserve assets. Furthermore, Reserve dental units have also been consolidated into the OHSUs to mirror changes implemented by Navy Medicine's active component.

EMERGING MISSIONS

Pandemics of influenza have occurred in the past and will likely occur again in the future. For the first time, however, the United States along with the global community have an opportunity to cooperatively plan and prepare for a potential influenza pandemic. The operational and medical leaders of the Navy are working together to develop operational tactics, public health techniques, and clinical capabilities to protect our active duty members, their families and our civilian workforce against this threat. Navy Medicine's efforts will be a key component of the larger plan being developed by the Defense Department.

Navy Medicine has proven to be an asset in providing humanitarian relief overseas and at home. Two significant examples are Operation Unified Assistance in the Indian Ocean and Hurricane Katrina relief in the Gulf of Mexico. Our most visible support in these disasters was the deployment of both hospital ships, USNS MERCY (T–AH 19) and USNS COMFORT (T–AH 20). The hospital ships have inpatient capabilities comparable to major medical facilities ashore. They each have fully-equipped operating rooms, inpatient beds, radiological services, a medical laboratory, a pharmacy, an optometry laboratory, a CT-scanner and two oxygen producing plants. Both have flight decks capable of landing large military helicopters evacuating casualties.

For six months after the December 2004 Indonesian earthquake and tsunami, teams of Navy medical personnel and health care providers from the nongovernmental organization (NGO) Project HOPE conducted daily humanitarian assistance operations on board USNS MERCY. Operating off the coast of Banda Aceh, MERCY's medical staff treated more than 9,500 patients ashore and afloat, and performed nearly 20,000 medical procedures, including more than 285 surgical and operating room cases. During a stop in Alor, Indonesia, MERCY's team cared for more than 6,200 patients, and during a visit to East Timor, they saw more than 8,000 residents.

On August 29, 2005, Hurricane Katrina struck the coastal areas of Louisiana, Alabama and Mississippi, causing many deaths, displacing a large civilian population, damaging infrastructure including health care and public health systems, disrupting communications, and generating devastating flooding. Navy Medicine deployed over 800 health care professionals in support of Hurricane Katrina relief efforts and, with the help of Project Hope volunteers, treated over 14,500 people. Our personnel deployed with USS BATAAN, USS IWO JIMA, USNS COMFORT, the Joint Task Force Katrina Surgeon's cell, Forward Deployed Preventive Medicine Units, mental health response teams, Navy Construction Battalion Units, as well as in direct support of Navy clinics in Mississippi and Louisiana. Navy Medicine coordinated supporting relief efforts with medical staff and supplies from Navy medical facilities across the country.

Earlier this year, U.S. military field hospitals in Shinkiari and Muzaffarabad provided the earthquake-stricken people of Pakistan with medical assistance. Navy Medicine's Forward Deployed Preventive Medicine Units and the Marine Corps' Combined Medical Relief Team 3 were located in Shinkiari while the U.S. Army's hospital was set up in the city of Muzaffarabad. Between these units, U.S. forces brought to bear medical capabilities including operating rooms, x-ray equipment, pharmacies, laboratories, and many other assets all in an effort to supplement organic Pakistani medical facilities which were hit hardest by the earthquake. Surgeons, general medical officers, nurses, and dentists were joined by other support Marines and Sailors in treating victims of this natural disaster.

MEDICAL RECRUITING

Although our missions continue to evolve, we, like the other services and the private sector, are struggling to meet all of our recruitment, retention and end strength goals in health care professions. The need for skilled doctors and nurses has been demonstrated time and again throughout the global war on terror; however, the number of medical school applicants and graduates in this country is declining. The

Navy, together with Navy Medicine, is working to improve recruiting and retention of doctors and nurses so we can meet our deployment requirements. Some of the efforts being considered include: improving compensation parity with the private sector; studying incentive programs that better meet the needs of the current student population; and offering an accession bonus and medical insurance coverage for student programs.

SUSTAINING THE BENEFIT/HEALTH CARE COSTS

Navy Medicine has a dual mission. While meeting the operational medical needs of our warfighters as illustrated above, Navy Medicine continues to provide the finest, cost-effective health care to America's heroes and their families at home and overseas.

The Navy is proud of the exceptional health benefit and health care delivery system that Congress and the Defense Department have built, expanded upon and improved over the years. In the last ten years, both congressional and departmental initiatives have addressed gaps in program coverage and improved access to care for millions of military beneficiaries. These new benefits have made a positive contribution to our recruitment and retention efforts, and we wish to sustain them for the long-term.

In order for the Department to sustain the benefits that so many have come to expect, the long-term costs of the program must be contained for the program to remain viable in the future. TRICARE benefits have been expanded and implemented; however, there have been no changes in beneficiary cost shares since 1995. The Department proposes to restructure beneficiary contributions to proportions similar to when TRICARE was established in 1995. These changes will ensure we will be able to continue providing the same high level of access and quality care enjoyed by our beneficiaries today. As Chairman Pace testified before you earlier this year, the Joint Chiefs have unanimously recommended that we renorm the cost sharing for the health care benefit.

As overall health care costs have grown for both the Department and the private sector, the expanding disparity in out-of-pocket costs between TRICARE and civilian health plans has led to a significant increase in the number of retired beneficiaries under the age of 65 who are now using TRICARE as their primary health insurance. This has resulted in an increase in the costs borne by the Department of Defense. The increased utilization, especially among this group of retirees, together with the expansion of benefits and healthcare inflation, have created a perfect storm. Costs have doubled in five years from $19 billion in fiscal year 2001 to $38 billion in fiscal year 2006. Analysts at Health Affairs project these costs will reach $64 billion by 2015, about 12 percent of the Department's budget (vs. 4.5 percent in 1990). This current rate of medical cost growth is unsustainable and internal efficiencies are not, and will not, be sufficient to stem the tide of rising health care costs.

The Navy honors the service and sacrifice of our active duty and reserve members and retirees, as well as their families. Because of their service and sacrifice the Navy continually strives to provide a truly outstanding health benefit for them. The Administration's proposals to manage cost growth and sustain this valuable benefit encourage beneficiaries to elect medically appropriate cost-effective healthcare options. A very important point of the proposals is that the changes in cost sharing will not impact active duty troops or retirees over age 65. In addition, catastrophic protections would remain intact for retiree families—at $3,000 per year.

The Navy strongly supports the words of Joint Chiefs' Chairman Pace and Secretary Rumsfeld and wants to work closely with the distinguished members of this committee and all of Congress to sustain this great health benefit for the men and women of our Armed Forces and their families. Together, we will sustain the vital needs of the military to recruit, train, equip and protect our Service members who daily support our National Security responsibilities throughout the world, keeping our nation strong.

CONCLUSION

Mr. Chairman, Navy Medicine has risen to the challenge of providing a comprehensive range of services to manage the physical and mental health challenges of our brave Sailors and Marines, and their families who have given so much in the service of our nation. We have opportunities for continued excellence and improvement, both in the business of preserving health and in the mission of supporting our deployed forces.

I thank you for your tremendous support to Navy Medicine and look forward to our continued shared mission of providing the finest health services in the world

to America's heroes and their families—those who currently serve, those who have served and the family members who support them.

Senator STEVENS. General Taylor.

STATEMENT OF LIEUTENANT GENERAL GEORGE PEACH TAYLOR, JR., M.D., SURGEON GENERAL, DEPARTMENT OF THE AIR FORCE

General TAYLOR. Mr. Chairman, Senator Inouye, and members of the subcommittee, it's a pleasure and privilege to be here today. Your Air Force Medical Service continues to serve America proudly, whether in caring for our wounded in the Balad theater hospital, in flying them safely home, in treating thousands of Hurricane Katrina victims or in providing quality healthcare to our home-station troops and their families.

During the gulf coast disaster, a Federal Emergency Management Agency (FEMA) physician told me that one of the most impressive things about our people is that they treated every patient during that chaotic, crowded, and terrible time, as if they were family, as if the person on the stretcher was their own father, mother, sister, brother, or child pulled from harm's way. I would add that this is true, from my experience, for all patients treated by Air Force medics, to include coalition forces, the Iraqis, and even the occasional insurgent.

To maintain this level of quality, ability, and esprit de corps throughout our Air Force, we are focusing on the three major challenges our Chief of Staff, General Moseley, has outlined—fighting the global war on terrorism, taking care of our people, and recapitalizing our valuable assets.

What we are accomplishing in Operations Enduring Freedom and Iraqi Freedom is phenomenal. If you had the opportunity to see the USA Today article and video published on March 27, you saw firsthand what incredible work our medics are doing across the services. The reporter, Greg Zororya said, quote, "To save lives in the battlefield, medical innovations are born in days rather than in years. And as with wars past, the new ways of treating the injured and sick in Iraq and Afghanistan have benefits beyond the battlefield," close quotes. He was absolutely correct. Through our in-theater experience, we are exploring uncharted territory in blood products and medical surveillance, telehealth, trauma response, and many more areas of cutting-edge medicine.

Our commitment to joint operations cannot be overemphasized. As part of the joint team, we have more than 600 ground medics in 10 deployed locations. In 2005, we treated more than 12,000 patients in Balad alone. Our Balad chief of intensive care, Colonel Ty Putnam, said, "The caseload rivals any major trauma center in the USA." That level of experience has resulted in unsurpassed survival rates. As a former Balad medical group commander said, "If you arrive here alive, you have about a 95–96 percent chance of leaving here alive."

The other crucial piece of our ability is to aeromedical evacuate our patients out quickly, getting them from point of injury to the States usually within 72 hours. The Air Force Medical Service was honored by the USO recently for the lives we've saved through our "critical care in the air" capability.

The value of the care we provide in theater with our sister services has been recognized in recent months by many grateful patients, among them Members of the U.S. Congress. The same capability to stabilize patients and quickly move them to higher levels of care was on clear display last summer on the gulf coast. I'm very proud of the role the Air Force total force team played in working with other Federal, State, and local agencies in moving over 3,000 sick or infirmed Americans from the devastated coast to shelters throughout the country, in addition to treating 7,600 people on the ground. But taking care of our people, General Moseley's second challenge is, and always has been, critical to the Air Force Medical Service. We continue to put great emphasis on deployment health surveillance of our troops. You know we are particularly concerned about them—you are particularly concerned about their mental health, as are we. Currently, Air Force post-deployment health assessments show only 1 to 2 percent of our redeploying airmen are experiencing—or expressing mental health concerns.

We recently rolled out the post-deployment health reassessment program, and we've received over 2,000 so far. Of those, 38 percent report some health concern, and about 5 percent report at least one mental health concern. While this may indicate that we are identifying additional problems, it's a little too early in the data collection to draw conclusions. We are watching this very carefully.

We are excited about the composite occupational health operational risk tracking, or COHORT, initiative which will assist us in tracking the health of our personnel, as it will provide occupational and medical surveillance data on every member, from the time an airman joins the Air Force until retirement or separation, opening up enormous fields of data never before available to us.

Our third challenge of recapitalizing our assets has become increasingly significant for the Air Force Medical Service. Six percent of our current facility inventory is more than 50 years old. By 2025, that could grow to 35 percent. With an annual military construction budget of $60 million, we find we have to phase any major construction out over several years. In fact, this $60 million, relatively flat for the past decade, now buys one-sixth the amount of construction it did 10 years ago.

BASE REALIGNMENT AND CLOSURE

We believe the BRAC process will help us relieve this situation as we combine facilities, close small, underutilized hospitals, or convert them to ambulatory surgery clinics. We also continue to seek ways to strengthen our partnerships in the civilian sector and with the Department of Veterans Affairs.

Finally, on behalf of our military families, I pledge my support to you and my fellow surgeons to work together to preserve the superb healthcare benefit that we offer. It is second to none, and so greatly earned and deserved by our military heroes and their families.

Finally, as this hearing began, the Chief of Staff announced my retirement, effective this year. I'd like to say what a privilege it is to have served the Nation for the last 27½ years, half of that serving an Air Force that's been in combat. The Air Force has been flying combat operations since 1991.

I've been part of an Air Force Medical Service that's made a difference. We've re-engineered our field hospitals, we've re-engineered our mirror medical evacuation system to allow people to move from foxhole to Bethesda in 36 hours. We've integrated into ground operations. A large portion of the ground-force support is done by airmen today.

A few things to think about. One is, I ask for us all to watch the BRAC implementation. There—as the head of the Medical Joint Cross-Service Group, working with the Base Realignment and Closure Commission, there are fairly innovative recommendations that need to be implemented, in terms of facility structure and combining facilities, and we just need to make sure that as we do this, it's not just the finances, but it is the change in the way we practice medicine, and changing the infrastructure, that the BRAC recommendations gives us a chance to rebalance. And so, we all need to pay attention over the next 5 years as we implement the recommendations that came through BRAC.

Second, I think we need to continue in areas where we're challenged with funds to watch for centralization. There is a lure of saving money with centralizing assets. The Air Force Medical Service is a highly decentralized operation, and that drives innovation very close to mission, innovation in field medicine, innovation in aeromedical evacuation, innovation in local healthcare. And I'd just say that we need to watch very carefully about centralization.

PREPARED STATEMENT

Finally, it's been my privilege to serve with a team of healthcare professionals throughout my career that I can only describe with one word, and that word is "magnificent," a magnificent group of people in a magnificent mission in a magnificent service, part of a magnificent Department, in the best country on the planet.

Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF LIEUTENANT GENERAL (DR.) GEORGE PEACH TAYLOR, JR.

Mr. Chairman and members of the committee, it is a pleasure to be here today to share with you stories of the Air Force Medical Service's success both on the battlefront and the home front.

The Air Force Medical Service (AFMS) continues to provide world-class health care and health service support anywhere in the world at anytime. This includes ensuring that active duty and Reserve component personnel of all Services are healthy and fit before they deploy, while deployed, and when they return home. It also includes providing the same quality of care—and access to care—for our 1.2 million TRICARE enrollees.

This year, our well-honed capabilities were important national assets in the medical response and evacuation of thousands of fellow Americans who were victims of Hurricanes Katrina and Rita. Our Total Force Airmen medics converged on the ravaged region twice in one month to work with Federal Emergency Management Agency (FEMA) medical teams to care for and transport thousands of ill patients. Overall, our Total Force medics provided health care for 7,600 people. Another 3,000, many of whom were critically ill, were safely aeromedically evacuated from the region.

During our response to these natural disasters, a senior physician in FEMA's disaster medical assistance team told me that one of the most impressive things about our people is that they treated every patient during that chaotic, crowded, and terrible time as if they were family, as if the person on the stretcher were their own father, mother, sister, brother, or child pulled from harm's way.

This catastrophic event, though, is something for which we are uniquely trained and equipped to perform. Obviously, the positive attitudes of our people and their

collective competence go a long way toward ensuring that the AFMS successfully responds to and overcomes any disaster—natural, domestic or foreign.

To ensure we maintain these abilities and attitudes, Air Force Chief of Staff, General T. Michael Moseley, has outlined three major challenges for leadership to focus upon: fighting the Global War on Terrorism; preserving our culture of excellence through the training and development of our people, and breaking the vicious cycle of operating the oldest inventory in the history of the United States Air Force through recapitalization.

GLOBAL WAR ON TERRORISM

The Global War on Terrorism will be with us for years to come. Among the Air Force's most critical components in successfully fighting this war both overseas and here at home is considering how we plan for our long-term requirements.

Key in accomplishing this is reinforcing that the Air Force is one organization—not active-duty, Guard and Reserve "tribes." This philosophy necessarily extends to interoperating with all of our sister Services, a method of warfighting that has taken—and will continue to take—growing importance unmatched at any other time in our nation's history.

Most certainly, our light, lean and mobile expeditionary medical support—or EMEDS—is the linchpin of our ground mission. As importantly, the Air Force Medical Service makes its unique contribution to the Total Force and joint operational environment through our aeromedical evacuation and en route care mission.

Significant as these two components are, we must also continually refine the Air Expeditionary Force deployment system; ensure the pre- and post-deployment health and fitness of our troops; and diligently work to maintain the technological edge over our enemies—overseas and in the United States—through the development of bio-surveillance and medical treatment capabilities.

EMEDS

EMEDS, especially at the Air Force Theater Hospital at Balad Air Base in Iraq, has validated the "golden hour" concept—the importance of delivering care in first 60 minutes after injury. This life-saving capability has proved its effectiveness, and no one illustrates the importance of its capability better than the joint troops who make it happen.

"If a patient requires surgery to survive, it will be done here," said Staff Sergeant Jalkennen Joseph, an emergency room medic. The reality and benefit of having a robust surgical capability forward has been key to the lowest casualty rate in the history of combat. Colonel (Dr.) Elisha Powell, former 332nd Expeditionary Medical Group (EMDG) Commander in Balad, supports this fact that "If you arrive here alive, you have about a 96 percent chance of leaving here alive."

We are proud of the teamwork between Air Force flight medics and the Army and Air Force medics on the ground in the patient administration office of our theater hospital as they prepare for the arrival of casualties. "I give all the credit in the world to flight medics . . . they do things you only see in movies or read about in books. They do it on a daily basis and they do it well." said Staff Sergeant Joseph. Moreover, although the Theater Hospital at Balad is largely staffed by the Air Force, the symphony of teamwork is its cornerstone. Joseph continues, "We have all really clicked together . . . we run this place smooth, doing the same mission. We live by the hospital motto 'One team. One mission.'"

In this light, we foresee a continued need for this important capability to provide health care anywhere, and we will continue to refine this to meet joint warfighting medical requirements.

Our commitment to Joint operations cannot be overemphasized. As part of a joint team, we now have more than 600 ground medics in 10 deployed locations. In addition to Balad, we also operate two smaller hospitals in Iraq—one in Kirkuk and another at the Baghdad International Airport. Every day, Air Force medics in these theater hospitals are saving the lives of Soldiers, Sailors, Marines, Airmen, civilians, coalition and Iraqi forces, friend and foe alike. We treated over 12,000 patients in 2005 at Balad alone. These included U.S. forces, Iraqi Security Forces, U.S. and Iraqi civilians, as well as a combination of coalition forces, third country nationals and detainees.

Because our medical teams are operating closer to the front lines than ever before, patients are getting advanced medical care within hours, not days or weeks as they had in the past. However, as our experience in the past four years has shown us, as important as beds and forward deployed health care is, equally important is the ability to quickly move patients from the field to higher levels of care.

AEROMEDICAL EVACUATION

Aeromedical Evacuation (AE) crewmembers perform many of the same life-saving activities their peers accomplish in hospitals, but in the back of an aircraft at over 30,000 feet. The conditions are sometimes challenging as crewmembers work under the noise of the engines or when flying through turbulence—but there is no place else they would rather be.

"It is a great feeling of responsibility and a privilege to care for these patients," says Colonel (Dr.) Peter Muskat, director of clinical training at the Cincinnati Center for Sustainment and Trauma Readiness Skills (C–STARS), who has flown 15 missions from Balad. Without a shadow of doubt, casualties aboard AE flights are entrusted to warrior medics well trained to effectively perform under these conditions. Colonel Muskat: "From the point of injury in theater to the time the injured person is medevac'd to the states, most times within 72 hours, they receive care from medics who have been exposed to every potential problem a trauma patient may face on the ground and during that flight."

It is crucial to emphasize that of our approximately 400 AE personnel deployed today, the majority of them—almost 90 percent—are Guard and Reserve. A better example of fighting together in the Global War on Terrorism simply escapes me—the Reserve Component contribution to AE operations represents an undeniable hallmark of Total Force.

Occasionally, our AE crews transport patients who are so ill or injured that they require constant and intensive care. When that happens, our AE medical capability is supplemented by Critical Care Air Transport Teams, or CCATTs. These are like medical SWAT teams that fly anywhere on a moment's notice to treat and extract the most seriously injured troops.

Team members carry special gear that can turn almost any airframe into a flying intensive care unit within minutes. An in-theater EMEDS commander told me that CCATTs are a good news/bad news entity. He said, "The bad news is, if you see the CCATT team jumping on a plane, you know someone out there is hurt bad. The good news is, if you see the CCATT jumping on a plane, you know that someone will soon be in the miraculous hands of some of the best trained medics in existence."

No where in recent AE operations was this capability highlighted better than when three members of a CCATT, Major (Dr.) Linda Boyd, an emergency medicine physician, Major Denise Irizarry, a nurse, and Master Sergeant Jeffrey Wahler, a respiratory therapist, were aboard a C–17 Globemaster III from Ramstein Air Base, Germany, to Andrews Air Force Base, Maryland. They treated 30 casualties including ABC anchorman Bob Woodruff and cameraman Doug Vogt. Major Boyd said, "It was awesome—we did intubations and ventriculostomies—a procedure where a device is place into the ventricles of the brain when needed to drain spinal fluid and relieve pressure." On a regular basis, our AE warrior medics leverage superior training, commitment to excellence, and talent to uphold our requirements to support America's heroes who defend our great nation.

Overall, partnering with our critical care air transport teams, our aeromedical evacuation system has made it possible to move seriously injured patients in an astonishingly quick time, as short as 72 hours from the battleground to stateside medical care—unheard of even a decade ago.

DEPLOYMENTS

When I joined the Air Force in the 1970s, we planned, trained, and equipped our medics on the basis of the threats faced in two major operational plans of short duration. That construct is no longer valid, as can clearly be seen with the Global War on Terrorism.

Today's Air Expeditionary Force structure was created, in part, in response to this new construct. The AFMS needed to restructure itself, too, so that it could face multiple commitments overseas of both short and long duration. Our nation requires that medics field combat support capabilities that are very capable, rapidly deployable, and sustainable over long periods.

Medics must be placed at locations where they can maintain the skills they need for their combat medicine mission. It is also vital that these locations allow the medics to deploy easily without significantly interrupting the care they provide the base or TRICARE beneficiaries, especially at those locations with sustained medical education training programs.

This challenge is straightforward: create expeditionary medics who are focused on developing the skills for the field and eager to deploy for four of every twenty months. Currently, we assign medics at large facilities into groups of five so that one team can be deployed at any one time while the other four remain to work and

train at home station. We also actively work the ratio of active-to-Reserve component medics to determine the proper mix of active duty and Reserve component to ensure the best balance between the ability to deploy quickly and the capability to surge forces when necessary.

We are also actively reviewing the total size of the AFMS to make sure that over the next few decades we can successfully fulfill our wartime mission while still providing the peacetime benefit to our members, retirees, and their families.

Finally, a vital part of our preparation is state-of-the-art training, such as our Coalition for Sustainment of Trauma and Readiness Skills, or C–STARS, where we partner with renowned civilian medical centers in Baltimore, St. Louis, and Cincinnati to allow our medics to receive trauma training. While our medics—300 in 2005—receive training that is unavailable in most of our stateside hospitals, we provide a service to the people of those cities—a mutually beneficial relationship that enhances preparedness both at home and abroad. Many students laud C–STARS as the best medical training they have received to prepare them for deployment.

DEPLOYMENT HEALTH

Collaborative arrangements among the medical, chaplain and family support communities support our claim the Air Force has personnel and processes in place to monitor and address health concerns before, during and after deployments.

Deployment Health Surveillance is a continuous process of Force Health Protection. From accession, through service, and into separation and retirement, the Air Force Medical Service is dedicated to ensuring the health of our Airmen. We maintain a robust Individual Medical Readiness program to ensure each Airman, active and reserve component, is assessed for deployability and mission capability. At the point of deployment, we conduct a tailored deployment health assessment to include appropriate immunizations, medications, and health communication of known threats in the deployment area. In OIF/OEF, these activities combined with continuous health support in theater have resulted in the lowest disease/non battle injury rate ever experienced in combat operations.

Although some of these efforts are strictly medical in nature, others focus on specific and increasing needs such as mental health. To address the mental health needs of deployed airmen, the Air Force deploys two types of mental health teams: a rapid response team and an augmentation team. Mental health rapid response teams consist of one psychologist, one social worker and one mental health technician. Our mental health augmentation teams are staffed with one psychiatrist, three psychiatric nurses and two mental health technicians. Deployed mental health teams use combat stress control principles to provide consultation to leaders and prevention and intervention to deployed airmen.

I was involved in the medical combat service support laydown for Operations ENDURING FREEDOM and IRAQI FREEDOM, and one of my highest priorities was to ensure that the Air Force fielded mental health professionals early and as far forward as possible to not only treat casualties, but to put in place strong prevention and outreach programs. Today, the Air Force has 49 mental health personnel deployed for current operations, 36 of whom are supporting joint service requirements. We also position psychiatric nurses at our aeromedical staging facilities to better address emerging psychological issues for all troops being medically evacuated out of the combat theater.

The Air Force and the Department of Defense have enhanced efforts to monitor and address the health concerns of deploying service members. Airmen complete the post-deployment health assessment (PDHA) at the end of a deployment, and are now being assessed again 90–180 days after return from deployment via the post-deployment health reassessment (PDHRA). These instruments provide an overall health assessment of our Airmen, with an emphasis on mental health.

A recent study published in the Journal of the American Medical Association examined the mental health problems reported by Army and Marine combat troops following deployments. We have examined the same data sets for Air Force personnel, and found that Airmen report significantly less mental health concerns following deployments than Army and Marine combat units. According to the report, while over 19 percent of Army and Marine personnel reported at least one mental health symptom after an OIF deployment, only 4.7 percent of Air Force OIF deployers reported at least one mental health symptom. Only about 1 percent of Air Force deployers were referred for mental health care following a post-deployment health assessment. The lower incidences of mental health problems for our Airmen are most likely attributable to both the type and length of Air Force missions. That said, we are closely scrutinizing deploying Airmen who may be at greater risk for mental health concerns, such as convoy personnel and medics.

The Air Force is also standardizing existing redeployment and reintegration programs to help Airmen and family members readjust following deployments. These programs are collaborative among the medical, chaplain and family support communities. Airmen and their families can also take advantage of The Air Force Readiness Edge, a comprehensive guide to deployment-related programs and services, as well as Air Force OneSource, a contractor-operated program that provides personal consultation via the web, telephone or in-person contacts, on matters that range from severely injured service member family impact to dealing with grief and loss to a myriad of other family related matters. Air Force OneSource is available 24 hours a day, and can be accessed from any location.

TECHNOLOGICAL EDGE

Terrorism confronts us all with the prospect of chemical, biological, and radiological attacks. Of those, one of the most disconcerting to me are the biological weapons. Nightmare scenarios include rapidly spreading illnesses so vicious that if we cannot detect and treat the afflicted quickly, there would be an exponential onslaught of casualties.

Medics have the capability to find, track, target, engage and defeat such biological threats, whether they are naturally occurring, like Severe Acute Respiratory Syndrome (SARS) and influenza, or man-made, like weaponized smallpox.

The rapidly advancing biogenetics field may provide the technology that allows us to identify and defeat these threats. Many consider the coupling of gene chip technology with advanced informatics and alerting systems as the most critical new health surveillance technology to explore—and we are doing it now in the Air Force.

In 2005, an Epidemic Outbreak Surveillance project, an Air Force initiative, was successfully tested during a real-world exercise in Washington, DC, that began shortly before the 2005 inauguration and ended after the State of the Union Address.

During the exercise, medical teams around the National Capital Region collected samples from patients who had fever and flu-like illnesses. The samples were transported to a central lab equipped with small, advanced biological identification units—a "gene chip"—that tested for common or dangerous bacteria and viruses. These results were known within 24 hours, not the days or weeks normally required. A web-based program then tracked outbreak patterns, providing an additional mechanism to automatically alert medics and officials of potential epidemics or biological attacks. We continue to work with this technology to create better diagnostics for our normal clinical work as well as for early detection of a new disease, whether it be avian flu or a biological attack.

We are seeking techniques to convert common tap or surface water into safe intravenous solutions in the field. We are also developing the ability to generate medical oxygen in the field rather than shipping oxygen in its heavy containers into the field.

Telehealth is another fascinating technology that enhances the capabilities of our medics. It allows providers in Iraq to send diagnostic images such as X-rays through the Internet back to specialists located anywhere in the world for a near real-time consult. This ensures that each Soldier, Sailor, Airman or Marine in the field has access to one of our outstanding specialists almost anytime and anywhere.

In 2006, we expect to start transitioning another advancement—our ability to create an unlimited number of cohorts of our beneficiaries using the Composite Occupational Health and Operational Risk Tracking (COHORT) initiative. This will provide occupational and medical surveillance from the time they join the Air Force until retirement or separation, regardless of where they serve or what job they perform. We will finally be able to tie together medical conditions, exposure data, duty locations, control groups, and demographic databases to globally provide individual and force protection and intervention, reducing disease and disability. These tools will work in near real time, and eventually will be automated to work continuously in the background, always searching for key sentinel events.

We are also proud of our collaborative efforts and pursuit of technological advances that extend beyond threats of biological or epidemic concerns, to also include advancements in more common diseases such as diabetes.

In collaboration with the University of Pittsburgh Medical Center, the USAF is actively engaged in diabetes research. The emphasis of this research is on primary prevention, education, and lifestyle modifications. The "test bed" includes both urban and rural western Pennsylvania, the USAF's Wilford Hall Medical Center in San Antonio, Texas, and rural Texas. The ultimate goal is to develop a template for the development of Diabetes Centers of Excellence that can be utilized across America to include the military community and civilian resources for poor under-privi-

leged regions. This research continuum and partnership will also add significantly to the development of a Diabetes Outreach Clinic at the Wilford Hall Medical Center that will ultimately serve the over 65-year old civilian community as well.

The program utilizes state-of-the-art educational principles and tools as well as groundbreaking technology. Telemedicine applications, videos, specialized retinal cameras (to demonstrate pathology) are some of the high-tech educational tools. A computerized Comprehensive Diabetes Management Program designed to promote self-management will be tested as well. These educational efforts target both adults with Type II diabetes as well as at-risk children. Biochemical research involving platelet derived growth factors as related to wound healing (for diabetes related wounds) are also under study.

Diabetes has become a major healthcare crisis in the United States. Currently, over 20 million Americans have diabetes and that number is growing at 8 percent a year. In an effort to halt this unhealthy trend, this program will develop the Premier National Model for diabetes education and treatment. The program is well underway and remarkably, beneficiaries are seeing fruits of this labor already.

PEOPLE

Almost half the people currently serving in the United States Air Force joined after September 11, 2001. They knew what they were getting into, and there's no question that the military's medical personnel are a critical component of the Global War On Terrorism. As such, one of the Chief of Staff Air Force's (CSAF) key priorities—get the right number of Airmen into the right jobs—takes on added significance.

The Air Force must have a balanced force of officer and enlisted Airmen. Force shaping is necessary to maintain the effectiveness of the Air Force and to maximize career opportunity for all Airmen.

Even so, the Air Force Medical Service (AFMS) continues to face significant challenges in recruiting and retaining physicians, dentists, and nurses—the people whom we depend upon to provide care to our beneficiaries. The special pays, loan repayment programs, and bonuses to our active and Reserve component medics are helpful in retaining people. In fact, nearly 85 percent of nurses entering the Air Force say they joined in large part because of these incentives.

The need to retain and recruit health care providers and specialists will grow as the military remains involved in the Global War on Terrorism for years to come.

As Assistant Secretary of Defense for Health Affairs Dr. William Winkenwerder, Jr., has said that the military medical community today is engaged "in a mission that, perhaps, has never before been so complex, challenging, or far-reaching as we find today."

Still, I am heartened by the caliber of the folks we continue to attract. One such person is Capt. (Dr.) An Duong, who, gave up her family medicine practice in Florida and came on active duty at Keesler Air Force Base, Mississippi, this year.

Doctor Duong was born in Saigon, South Vietnam, in 1971 and emigrated to the United States from the communist-held country at age 14 with her mother and two siblings. Now an American citizen, she said that part of the reason she joined was because of her early upbringing in a communist country. She said: "America adopted me and raised me. I owe her a lot."

She also said she was not fearful—but willing—to serve in a war zone. "I'm not intimidated about war. I was born into war—a child of war."

As we work to balance the force with the right combination of active duty, reserve component, civilian and contract staff, we must keep in mind that we deploy people, not our hospitals and clinics. We take care of the nation's heroes, past and present, and it takes the finest of medical staffs to care for this country's finest.

RECAPITALIZATION

We recognize the importance of maintaining a modern and effective infrastructure in our military treatment facilities, from clinics to medical centers. This is essential as we consider how the Air Force plans for its long-term requirements. The atmosphere in which our medics work is as important as any other retention factor. Our patients deserve not only the most brilliant medical and dental minds, but also first class equipment and facilities.

Though the TRICARE contracts create a strong civilian support system to augment the care we provide in our direct care medical treatment facilities. We continue to work to improve the quality of military health care with to investments and modernization of key medical facilities, replacing aging infrastructure, and to improvements in health care delivery efficiency.

When General Moseley recently stated that the Air Force is operating with the oldest inventory in the history of the Air Force, he was largely referring to our aircraft inventory. But that assessment also applies to medical facilities with the AFMS.

As an example, six percent of our current inventory is more than 50 years old; by 2025, it could grow to 35 percent. We've spent $30 million in less than two years to fix structure failure at our 46-year-old facility at Tinker AFB, Oklahoma. We've fixed safety code violations in five facilities, which ranged in age from 30 to 48 years.

This kind of budgetary pressure has changed the way we think about healthcare facilities. One initiative we are proud of is our clinic replacement at MacDill AFB, Florida. This 236,000 square foot new clinic will include a drive-through satellite pharmacy, which will consolidate 20 buildings and reduce our medical footprint by 25,000 square feet. Phase one of this project will cost $55 million in fiscal year 2007. When completed, we will have replaced the oldest AFMS hospital in the United States; and we will provide $4 million annual savings to the Military Health System. But what is important to understand is that the specialists at MacDill will actually perform their inpatient work at the civilian medical center in Tampa.

As part of the recent Base Realignment and Closure (BRAC) process, DOD will operate on a more rational, modernized footprint. Through the combination of facilities, the closure of small hospitals, and the combination of similar educational and research activities, we will be able to take advantage of new partnerships, both inter-service and with our civilian and Department of Veterans Affairs partners. These BRAC decisions support strategies of reducing excess capacity and locating military personnel in activities where the workload is more diverse, providing them with enhanced opportunities to maintain their medical currency to meet combatant commander requirements. I strongly support the BRAC law and am fully committed to its complete implementation. It is right for military medicine and, as importantly, it is right for our patients and our staff.

We strive every day to ensure that the Military Health System is the best health care system for the dedicated men and women in uniform who sacrifice so much.

TRICARE

Across the services, we believe TRICARE is great health benefit and a superior program that supports the warfighter and the family at home. On behalf of the Department, General Granger, deputy director and program executive officer of the TRICARE Management Activity says, "We know we have a nation that is at war, and were going to continue to make sure that we maintain those superb benefits that we need to support this long and drawn out global war on terrorism."

The military health benefit has gained critical attention recently due to the Department's proposed initiative to sustain this important benefit for the future. Understand that we honor the service and sacrifice of our active duty members and retirees as well as their families. Because of their service and sacrifice the Department continually strives to provide a truly outstanding health benefit for them.

We must sustain this health benefit into the future; to do so, we have implemented management actions over the past few years and these continue. However, and this is critically important, these actions alone will not stem the rising costs of the military health benefit. Costs have doubled in five years from $19 billion in fiscal year 2001 to $38 billion in fiscal year 2006. Our analysts project these costs will reach $64 billion by 2015, over 12 percent of the Department's budget (vs. 4.5 percent in 1990).

Several factors contribute to this cost spiral: expansion of benefits, increased beneficiary usage, especially among retirees, healthcare inflation, and no increase in beneficiary cost-sharing since the TRICARE program began eleven years ago.

Our proposals to manage cost growth and sustain this valuable benefit encourage beneficiaries to elect medically appropriate cost-effective healthcare options. Significantly, our proposals, which seek to, as the Chairman of the Joint Chiefs of Staff put it, "re-norm" contributions to approach those when TRICARE was established in 1995, will continue the high level of access to care and quality enjoyed by our beneficiaries today. We are also recognizing differences in cost-sharing to be expected from retired officers versus enlisted personnel.

We fully support these proposed changes and believe together we will be able to sustain this great health benefit for the men and women of our Armed Forces. It is critically important to place the health benefit program on a sound fiscal foundation for the long term.

In so doing, together, we will also sustain the vital needs of the military to recruit, train, equip and protect our Service members who daily support our National Security responsibilities throughout the world, and keep our nation strong.

SUMMARY

As we enter the fifth year of the Global War on Terrorism, we are engaged in combat and in humanitarian operations overseas and at home. From the Gulf of Mexico to the Persian Gulf, well-trained, dedicated, and compassionate medics from every service are making a difference in the lives of thousands of warriors and civilians. This blending of increasingly interoperable talent and equipment has made the miracles of today's battlefield medicine possible.

In conclusion, a recent comment by General Moseley, perfectly describes our future and the challenges we face. "When someone asks you what the Air Force will be doing in the future, tell them this: We will do what we have always done. We will stand on the shoulders of giants. We will take care of each other and every member of this great fighting force. We will innovate. And . . . we will fly . . . we will fight . . . and we will win."

Senator STEVENS. Thank you all very much.

You know, as we go to visit the hospitals at Walter Reed or Bethesda, we note the extremely high morale of your forces in the medical-care area. It's just astounding, and it's reflected in the type of care that these wounded service people are getting, and their attitudes. I have said before—I think Senator Inouye has experienced it, too—I have yet to talk to one of those wounded people that didn't ask me to sort of bend down and listen to them. And the comment's been, "They're treating me fine, but when can I get back to my unit?" The morale of this generation is just staggering for us. So, we thank you all for your service and what you're doing.

We are a little worried. For instance, I am worried, when I hear that the health professional scholarship program (HPSP)—that the Army and Navy were unable to fill the slots that were allocated to young people who are seeking those scholarships. There weren't enough seeking the scholarships. What's the reason for that? Is there not enough publicity or lack of interest of the new—coming generation in such education? What do you think, Admiral?

Admiral ARTHUR. Well, I think there is a combination of factors. Certainly, there is less interest in military service. And a lot of those people coming into medical schools don't know about the health professional scholarship program. And I think it would behoove us to do a better job of publicizing the scholarship, but also publicizing the kind of experience that they get in the military health system. If they knew that we never asked any of our patients how sick they can afford to be, I think that would change their opinion of whether to practice medicine in the military. If they knew that all of our patients are patriots, and they're all insured, and we don't have to worry about those kinds of issues, it would change their opinion. I think if they were given an opportunity to come into any of the services hospitals and see the camaraderie, the morale, and the quality of care that's given, they would be more apt to come in.

What we have done is work with our recruiting command, and we're now going to have physicians recruiting physicians, nurses recruiting nurses, instead of leaving that to the recruiting professionals. I think it's much better to have a young physician or a young nurse recruiting people who would want to come into the profession. We will select people who have been out in the operational theater, who have had some experience in the Navy, either

in the Navy or the Marine Corps, and can tell the young people in medical school that this is a truly rich, professional atmosphere, as well as one that has other elements of service that are not found in the civilian sector. We're also increasing the amount of pay that we will give them. And you know that Senator Mikulski has supported legislation that has given us the ability to do health professions loan repayments. And we are doing that for nurses, podiatrists, psychologists, and other health professionals.

So, I think it's going to get better. We are also going to be sending more physicians to meetings where part of their meeting obligation is not just to attend and get education, but also to be part of the recruiting booth, and to just be there to talk with people who would come up and ask them about their professions.

Senator STEVENS. Do you have any comment about that, General Kiley?

General KILEY. Yes, sir. Yes, Senator. I actually agree completely with Admiral Arthur. I'd say there are some other forces at work in our schools—medical and dental schools. I think there are other opportunities for students to get scholarships and to have stipends. The military is not the only way that students get through school.

I think there is a perception that they get of the military, particularly military medicine, based on what they see on the television and hear in the reports. And, as Admiral Arthur articulated, they don't understand the full depth and breadth of opportunities for all doctors, dentists, nurses, physicians assistants (PAs). We're doing exactly the same thing as the Navy. We recognize this. Army has been recruiting HPSP through recruiting command, but it's much more effective to have doctors recruiting doctors and nurses recruiting nurses.

We've developed a new DVD. I've personally communicated with the deans of every medical school and osteopathy school in the Nation and asked for access, and have been very pleasantly surprised and pleased with the very positive responses. We've actually identified a group of physicians who have stepped up and said, "I'd like to help with recruiting." Just like with the Navy, we're sending them to professional conferences, the American College of Obstetricians and Gynecologists meets next week, and we're going to have a booth there, with doctors in uniform, to talk to people that might be interested in it.

And, of course, it's not just about the students, it's about their parents, it's about spouses, and the perceptions.

So, I think we're paying a lot more attention than we were. I am concerned that we've—we have fallen short with dental and medical HPSP. We may not see the impact of that for another 4 to 7 years down the road, but we're getting very aggressive, in terms of offering these scholarships, both for the Active and Reserve. And I think we'll see that turn around. And I—we've had some very good data and information on retention that goes with this—with the sessions. Started a new process where we look at our doctors who were finishing their obligation in 2005, at the end of the fiscal year. And we looked at what they did. There were about 283, I think is the number.

My fear was, 15 to 20 percent of them would sign up for further obligation, either through training or bonuses. Close to 55 percent

signed up for more obligation, which is very heartening. And we're going to do this for our nurses and dental officers, so that we have the data to track this in the Active. Our Reserve forces are more of a concern for us, and we're getting more aggressive with recruiting in the Reserve forces, also.

Senator STEVENS. Thank you. We'd be pleased to work with the Ad Council with your services to try to get them to emphasize the availability of these scholarships and advantages to young high school graduates and to college students.

General Taylor, you remarked about your service's care, particularly the critical care in the evacuation process. Are you concerned about the level of funding that you have available for 2007 as we continue this process now?

General TAYLOR. I think the President's budget allocates money to the direct-care system that appears to be adequate for fiscal year 2007 to cover our needs for peacetime work, as well as what's in the supplemental request, to cover the warfighting request. I think we have the right staff right now. We have some areas of shortage, in terms of personnel; less so in the warfighting specialties, except in the nursing area. And I think General Rank will talk about that. The budget for 2007, appears to be a well-balanced budget for the direct-care system.

Senator STEVENS. Well, staff tells me that, overall, you've got a 10-year low in retention of professionals in the Air Force. Do you have any suggestions what we might be able to do to help you on that?

General TAYLOR. Sir, I think there are a couple of things that we've been working with the staffs, in terms of changing the environment of care. And one of the things I've talked about is making the practice attractive for folks to stay in. And part of that is making sure that we have facilities and equipment and supplies and a range of practice that appears adequate for them.

In terms of pay and fees and those sort of things, we need to make sure that we're exploiting, as best we can, all of the availability of pay options and loan repayments for our folks, for them to be able to stay in longer.

The near-term problem we have is in recruiting replacements. We filled our health professions scholarship program last year, plus 21; we appear to be filling the program fine today. We've been working with the Uniformed Services University of the Health Sciences (USUHS) to expand their medical student throughput. The problem with all of this is, those pay off 8 to 10 years in the future.

In the near term, we have holes in certain specialty types across physicians and dentists and nurses and other types that we need to make sure we have the right authorities that we can attract people into the system. One of our toughest problems is to get people into the system, particularly the fully trained providers.

Senator STEVENS. I don't have much time——

Admiral ARTHUR. With regard to——

Senator STEVENS. Pardon me.

Admiral ARTHUR. Yes, sir. Yes, sir.

Senator STEVENS. I don't have much time left, but I've been concerned about the articles and the conversations I've had about the

monitoring and treatment of those who are at risk for post-traumatic stress disorder. And I wonder if we're doing enough to interview and to deal with military people as they come out of the theater immediately. It seems that the longer that that is ignored, the more it increases. Am I wrong? Admiral Arthur?

Admiral ARTHUR. Yes, sir. We're doing quite a bit. We are embedding psychologists and other healthcare professionals into the units so that they don't have to go somewhere else to get the counseling or to get some kind of a social service referral service. So, the counselors and trained professionals are in the units. And as they come back, they work with them. They work with them, both in the combat theater, in transit, and when they get back home.

It is really the Reserve component and those who get out of the military right after they come back from combat with which I am most concerned. And we've worked with the Veterans Administration (VA) and extended the TRICARE benefits to be able to take care of them.

Now, these signs are very subtle. And so, we want to be sure that we detect them in the units and have people there who can talk with them and get to know the individuals. I think that's the best way to do it. It's worse if you let it go, and you see it in the families or in the employment venue. I think we've got a lot of energy into this, because we realize that everyone who goes into combat is significantly affected by it.

Senator STEVENS. Well, thank you very much.

Senator Inouye.

Senator INOUYE. Thank you very much.

I'd like to continue the line of questioning. Whenever I've had the pleasure of visiting troops on a carrier or on an airbase or an Army training post, I always set aside an hour to meet with enlisted personnel without the presence of officers. And it never fails, the first subject brought up is healthcare, about their dependents.

Using that as a background, I've been advised that the Army is below its required end strength. For example, psychologists are staffed at 88 percent of its required end strength; family practice physicians, 81 percent; surgeons, at 65 percent; emergency medicine specialists, 70 percent; pediatricians, 65 percent; social workers, 75 percent. And these are just some of the shortages.

When one considers that we've been operating with these shortages, and yet we are able to maintain the morale we have, as our chairman described, and the efficiency and the quality of service, your effort is almost heroic, but you can't keep it up that way. Now, what is the Army going to do to address this retention and recruiting problem?

General KILEY. Senator, as you know, that's a critical question for us. You've articulated some of the very worst data. I've alluded to some of the things we've started, with our peer-to-peer program, where we're going out to talk to pediatricians, to talk to psychologists, to talk to neurosurgeons, to talk to general surgeons, about service in the Army. In some cases, for example, with certified nurse anesthetists, we were able to begin to give them a retention bonus, which has helped. And we have just recently been approved, although we haven't funded, a retention bonus for our physicians

assistants, who are critical providers, particularly on the battlefield.

We've been able to maintain a high quality of healthcare for our soldiers and their families, and particularly manage casualty receiving and, frankly, mobilization and deployment, because our commanders have had the support of Congress and the support of the Department in allowing the local commander to not only use uniformed providers, but to have the flexibility to hire civilian and contract providers. It's a more expensive way to do business, in some respects, but it does help us in areas where we've got a fairly robust healthcare system.

I'm confident that with some of the scholarship and loan repayment programs that we've got in place, plus the focus that we've been placing, and not only for physicians, but for doctors, and particularly for the nurse corps, led by General Pollock, I think we're going to turn this thing around. I don't know that I'm going to have absolutely as many neurosurgeons as I need.

I think we've also got to address retention, because the more physicians and others that we can retain—and, frankly, many of these providers have articulated that their service in combat—in the combat zone, and their service in caring for soldiers, and the families of soldiers that have been in combat, has actually given them a new vision as to why they're in military medicine. It really comes home to them. And, as I alluded to, when I thought we were only going to retain 15 to 20 percent of our physicians in fiscal year 2005, we retained over 50 percent.

I think we're—I'd like to think we're at a nadir in some of these issues. But I think we need to continue to work at looking again at bonus levels. We've just now started to feel the impact of the increased bonuses that you all provided us in the 2003–2004 timeframe. So, I think we probably—with God's help, we'll be back here next year telling you that we've started to turn this around.

Senator INOUYE. Well, is there anything we can do, here? Is it money?

General KILEY. Sir, I don't—from my perspective, I don't think it's money. I think we've got a package of bonuses and opportunities for loan repayment. We've just started some of these new things in the last 3 to 4 months. I, frankly, have, in the future, a couple of other strategies, if these don't work. I might consider taking Army Medical Department (AMEDD) recruiting and asking the chief to pass that back to me, as the surgeon general, where it was back in the 1970s and 1980s, before U.S. Army Recruiting Command did it. But I think right now our best strategy is to work with them. And, frankly, recruiting command has been absolutely superb, even from a financial perspective, in assisting us in our efforts to get to medical schools, to get doctors to medical schools, nurses to nursing schools. I think General Pollock may talk to you a little bit about her efforts coming up this weekend.

So, for right now, the Congress has been so good to us on these that I'm not ready to come back and ask. I do think there's a financial issue. I mean, dentists are living in private practice, fairly robust salaries. We compete with that. Despite the fact that physicians in some areas of the country are working hard, or having trouble with—or issues with medical malpractice premiums, et

cetera, there's a perception in some that, you know, it's better on the outside. I think we have shifted that a little bit with the care that our providers are providing to injured soldiers and their families. So, I think we're on the cusp of that right now. I think how things go in current operations over the next 12 to 18 months may also give us an indicator of our retention.

Senator INOUYE. Admiral, in fiscal year 2005 the Navy was required to convert 1,772 medical professionals from military to civilian.

Admiral ARTHUR. Yes, sir.

Senator INOUYE. And you are 74 percent successful. Now, you're discussing the possibility of converting 10,000 medical professionals into civilians?

Admiral ARTHUR. Well, sir, actually, we were asked to convert those 1,700. We have decided only to convert 1,100 of those. And the balance are people that we've saved as we consolidated some functions, some medical and dental functions. So, the 74 percent is actually 74 percent of 1,100. We've found it very challenging to get the quality of healthcare professional—whether it's doctor, nurse, physician assistant, or podiatrist, social worker—that would meet the Navy's high standards for the salary that we're able to pay. So, we're finding it a challenge, especially in some isolated locations, to find healthcare providers who will come and work there full time. We can get locum tenens, people who come in for 2 weeks or 1 month at a time, but that's not the kind of continuity that we really want for our beneficiaries.

The additional conversions are conversations that we're having within the Pentagon as part of the Quadrennial Defense Review and its derivative, the Medical Readiness Requirements Review. And we're looking at the requirements for all kinds of combat service support, stability operations, humanitarian assistance, the full spectrum of military mission. There is thought that we should only staff for the combat casualty care portion of that, and to staff many of our overseas and isolated continental U.S. facilities with civilians, rather than U.S. military.

We are participating in those discussions, and I think that the number will be far less than 10,000, but it will still present a significant challenge to us, especially overseas, where the education may be good, but the interface with our American servicemembers may not be the best. And we have promised American-standard care for all of our soldiers, sailors, airmen, and marines, wherever they are, overseas or in the continental United States.

Senator INOUYE. General, you have served us well, and you're just about ready to retire. And so, maybe you can speak with a little more objectivity. There's been a lot of discussion on a joint medical service command. What do you think about that?

General TAYLOR. This is a work in progress within the Department to look at the joint activities. If you look at a marine who goes down in Fallujah, he can arrive in Bethesda 36 to 48 hours later, going through eight care teams, pretty remarkable bit of work, with a high survival rate. We focus on that. We also focus on the unique missions that each of the services have.

So, as we look to build some sort of joint or unified command, we have to be very careful that we retain not only the capability

to make joint activities, like moving that marine from Fallujah to Bethesda, work well, but also the unique missions that the services have.

So, I think it's a work in progress. The Department's looking at various options in a more jointly run medical set of services. And I think we need to let that play out. The Air Force Chief of Staff's position on that has been, "Let us see what the alternatives are, and see what the impact is," particularly on the Air Force. As I said, we don't run an Air Force medical command. We run a decentralized system. And so, it's a much larger leap for us to move to some sort of unified command than it would be for the other services.

Senator INOUYE. I've got 7 seconds. Do you agree that it should be a joint command?

Admiral ARTHUR. Yes, sir. I think there's great advantage to doing single common training, acquisition of supplies and equipment, have a single mission, singly financed, singly measured, but I also agree with General Taylor that every service has specific missions—care in the air; we have submarine medicine; the Army has other types of medical support to their combat forces. And we need to ensure that we meet the service's needs. And this is not to meet the medical system's needs, but to meet the service's needs for combat service support.

General KILEY. Yes, sir. We have "care in the dirt." They have "care in the air." We have "care in the dirt"—I very strongly support unified medical command.

Senator INOUYE. Thank you very much, Mr. Chairman.

Senator STEVENS. Senator Mikulski.

Senator MIKULSKI. Well, good morning, Admiral, Generals.

First of all, know that it's really an honor to be the Senator from Maryland, because we, in many ways, feel we're the home of military medicine, from the Bethesda Naval Hospital, to having the Uniformed Services University of the Health Sciences (USUHS), to having Fort Detrick, and even the hospital ship *Comfort* is in our State.

I also just want to say to you, and to our nurse corps leadership and to all of the people who serve, just how proud we are of you. What you all are sustaining is enormous, and in the midst of a war. Amidst these tremendous battlefield casualties and taking care of dependents, along comes something called Katrina that you had to respond to, along comes a pandemic that we have to be getting ready for. And I know you're planning for that. So, we just want you to know, we're very proud of you. And, as my two colleagues have said, you can't talk to a soldier that's come back who just wasn't proud to serve his country, but expresses the gratitude to the medical care, even for the infections. You know, we hear about the battlefield trauma, but it's the urinary tract infection that the young female soldier has, and it's the fungus infection, the foot infection that the young marine or infantryman has. So, it's all that usual and customary. So, we're just very impressed.

Let me go to the battlefield aspects of medicine, just for a minute, and to General Taylor. I understand that these evacuations, the golden hour from battlefield to Walter Reed, are an amazing and stunning accomplishment with, obviously, lower mor-

bidity and mortality. Can you sustain that on the basis of the National Guard and Reserve? Because I understand that the majority of how that occurs comes from the National Guard and the Reserve. They provide the air infrastructure, and then you provide the staff, shall we say, in the hospital room in the sky. Am I correct in that?

General TAYLOR. It's a little bit of both. We have teams that are in the air, in the back of the airplane, and they are a mixture of Guard and Reserve and Active. The most impressive part is, by and large, we do this with volunteers. The people that are in the air—the thousands of men and women that are in the aeromedical evacuation community, both Active, Guard, and Reserves, are a highly motivated, well-trained group with a fairly substantial depth, because we had to plan to move as many as 300 or 400 casualties a day, in the opening days of the war. And so, moving 10s and 20s a day is well within the realm of our aeromedical evacuation capability.

Senator MIKULSKI. Yes, but are you able to sustain this?

General TAYLOR. Yes, ma'am. We're doing it with volunteers today, and very little mobilization, and we see that we're able to do that for the foreseeable future.

If I could just add one thing to your list of——

Senator MIKULSKI. Yes.

General TAYLOR. In addition to Bethesda Naval Hospital and other places, I'm also very proud of the Baltimore Shock Trauma Center. As you know, we have military surgeons and nurses and technicians working in the Baltimore Shock Trauma Center every day. We rotate surgeons and nurses and technicians and other folks through there for training, and large numbers of people that you see working in the air or on the ground in Balad are graduates, recent graduates, of the shock trauma orientation course, where they go and take care of people.

Senator MIKULSKI. Yes, well, in my time, in 10 minutes——

General TAYLOR. Yes, ma'am.

Senator MIKULSKI. I'm aware of that.

General TAYLOR. I just wanted to add one more comment.

Senator MIKULSKI. Yes, I'm aware of that. And we're proud of that—which takes me to the recruitment issue. I'll be talking a lot with the nurse corps about their particular issues, but when we talk about the medical corps and the variety of very sophisticated specialties, General, are you looking at how you can get to the medical students while they're medical students with these kinds of partnerships between military medicine and perhaps a local civilian medical school? In other words, where you have a big military presence, like we have in Maryland—it could be Oklahoma, it could be South Carolina—where there you are, there's the military, and there's the civilian medical system, where there is exposure, a lot of these kids don't know about the military. Their fathers don't know about the military, or their moms, because, again, we don't have a draft. They just don't know. And decisions are made at the medical student level, not where they're going to do their residency and find it enormously exciting to be, for example, what General Taylor talked about.

General KILEY. Yes, ma'am. We are—we're very interested. In fact, part of this thrust for the digital video disc (DVD), which we've developed, which is part of a presentation by Army physicians who go to medical schools, to the large classes, particularly freshman and sophomore, and show them the DVD and give them an opportunity to talk about all the options, possibilities, either research, clinical care, academics and teaching, and then operational medicine. What we've changed, in an effort to address your concern, is to focus recruiting efforts and the tools that we use, focusing them on physicians, specifically. I think, in the past, one of our shortfalls has been, we've had this Army Medical Department recruiting effort, writ large. And if you're a doctor, you don't see enough in there to identify with. If you're a nurse, you don't see enough in there to identify, to help you understand. So, that's one thing.

We've also began to look at pre-med classes, the universities where the medical students are, before they go to medical school, because we'd like to get to them while they're still juniors and seniors in college, thinking about going to medical school.

Senator MIKULSKI. Well, is one of these obstacles to recruitment the money? Or is it the lack of knowledge and awareness about these career opportunities?

General KILEY. Off the top of my head, ma'am, I think the answer would be captured in an article that was in Military Medicine a few years ago, "Canvassing Medical Students in Medical School: Don't Know, Don't Care." I'm not so sure they don't care anymore, because of our global war on terror efforts, but they still don't know. I think it's less about that than it is about money. There are, as I alluded to a little bit earlier—as I understand it, there are potentially other competing interests for repaying loans and giving individual stipends in medical school. I think, mostly, it's education. And, frankly, we've got a tremendous cadre of young enlisted recruiters. But when the doctor—when a medical student wants to know, you know, can they be a pediatrician, or are they going to have to be a this——

Senator MIKULSKI. They don't have the answers. Well, this is why I think, through, again, the pre-med level is excellent, but I think it requires creative outreach. And I think, you're exactly right, where you think you're going to be is who you want to talk to——

General KILEY. Right.

Senator MIKULSKI [continuing]. Whether it's in allied health, not only are we going to talk about nurses, I know there is a shortage of pharmacists, x-ray technicians. We could go the cadre, because of what we see in the civilian population. So, we want to be able to help you be able to do that. So, that's one thing.

General KILEY. Right.

Senator MIKULSKI. Second thing is, while we're talking about the battlefield, I'm also concerned about some other threats, like the Katrina-like natural disaster, to be ready in our own country, should there be a predatory attack and local government collapses, or if a pandemic hits and your doctors and your nurses and your own institutions could go down, just like in Katrina, where you had nurses and doctors carrying people eight flights of stairs to get

them out. What is the thought and the planning there? And are we stretched so thin now that we would have limited resources to deal with a catastrophe within the homeland, regardless of whether it's natural or predatory? For any of our panelists.

General TAYLOR. I'll be glad to—I'll say a few things, and then maybe Kevin can kick in afterward.

The medical services within the Air National Guard have been tasked by General Blum to begin moving toward a homeland security defense. So, they are organizing their capabilities, along with the FEMA regions. They're building response capabilities, and they're organizing and practicing for a national disaster, not only because the Guard's immediately available, but with State-to-State agreements, there is also rapidly available without having to wait for the Do loop through the Federal Government.

And so, I'm very excited about that. There was a recent exercise last week, called Coyote Express, in Scottsdale, Arizona, where they practiced. How would you respond to a major casualty event? I think you have it right, that people think about first responders in any sort of national disaster, without thinking about——

Senator MIKULSKI. They, themselves——

General TAYLOR [continuing]. First——

Senator MIKULSKI [continuing]. Could go down.

General TAYLOR [continuing]. The first receivers. Is there going——

Senator MIKULSKI. What about the——

General TAYLOR [continuing]. To be anybody at the end of the——

Senator MIKULSKI. What about the pandemic? My time is——

General KILEY. Yes, ma'am. Actually, U.S. Army Medical Command just finished a three-part CPX/headquarters exercise with all of my regional commands, walking through a what-if scenario. If the Army was asked, in this case, to help the local civilian communities—you've identified an area that concerns us. I mean, it has the potential to be a very significant impact on the Nation. I think all three services are concerned about that. I think we would be simply waiting for direction from the Department to begin to execute that. And I know that my commanders, at places from Fort Lewis to Walter Reed, are talking with——

Senator MIKULSKI. You're waiting for the direction from who, General?

General KILEY. Well, I mean, in the event of a pandemic, we—you know, we would—we would expect the Department or the President to give us direction to begin to execute mission support outside the fences of our camps, posts, and stations. What we're not waiting for is getting to know who in the communities, both medical and civilian leadership in the communities, has accountability and responsibility in a Seattle/Tacoma or in Fairfax, Virginia, as it relates to how a community would react to and support the medical demands for a pandemic in an area. And they would be very significant. And our analysis, as we've worked our way through this, the last couple of months, is, it would be a very significant problem, everything from the health of our providers to the logistics of taking care of a community.

So, we share your concern. We are training now, as I guess——

Senator MIKULSKI. Well, again, I think this is just something that we'll be talking about, because it really has a real national security impact. In the event of an emergency like a pandemic, it's very likely that the very people who have to treat could, themselves, be sick, in the local community. The second thing is, the massive treatment, the massive inoculation, and then the need to maintain civil order and possibly even a quarantine, and the only place that we can turn to with the backup reserves, even under the doctrine of mutual aid with first responders, is our United States military. And you're stretched—and you are—you're doing a fantastic job, but I believe you're stretched. And so——

General KILEY. I——

Senator MIKULSKI [continuing]. We'll look forward to further discussion on this.

General KILEY. Yes, ma'am.

Senator MIKULSKI. Thank you.

General KILEY. We agree with you.

Senator STEVENS. Well, thank you very much.

We thank you, General Taylor, for your service, and wish you well.

Senator MIKULSKI. Yes, I wanted to say that, too.

Senator STEVENS. Admiral, I'm interested in your answers to Senator Inouye's question about integration. I think we'd be very pleased to see if some of you would take the initiative to get your groups together and some of your predecessors, see if we could have a meeting with the eight Members of Congress who really lead the four defense committees. It may be time for a defense military corps with some type of training that would be—would specialize in the necessities for the marines, the Army, the Air Force, the Navy, whatever it might be. But, very clearly, it appears that the integration of the medical services could have a substantial benefit, and could raise the level of awareness of the corps and what it means to the country. So, I think that the two of us would be very pleased to work with you on that, if—when some of these current travails are over here, sometime this fall.

Admiral ARTHUR. Yes, sir.

Senator STEVENS. We'll give you a call.

Admiral ARTHUR. Yes, sir.

Senator STEVENS. Let me thank you all for your service, and——

Senator INOUYE. May I also——

Senator STEVENS. Yes, Senator.

Senator INOUYE. Before we dismiss the panel, I just wanted to make a footnote. According to my studies, a military radiologist receives $150,000 a year. One on the outside, a civilian radiologist, with similar skills and experience, would get at least $450,000.

Admiral ARTHUR. Yes, sir.

Senator INOUYE. You've got a job ahead of you.

Admiral ARTHUR. And if we asked them to work side by side in military/civilian conversion, it's an incredibly demoralizing situation. When one works nights, weekends, and deploys, and the other does not, but gets three times the salary—yes, sir.

Senator INOUYE. I hope Americans realize the bargain they're getting on our military personnel.

Admiral ARTHUR. Yes, sir.

General KILEY. Yes, sir.

Senator STEVENS. Some of my former assistants here in town are making $1 million right now. We don't want to do some comparisons.

Thank you all very much for your service.

Senator STEVENS. We look forward to working with you on this subject. We'll turn to the next panel.

We're going to hear now from the chiefs of the service nursing corps. This subcommittee has always believed in the value of the nursing corps. It is vital to the success of our military medical system, and absolutely necessary in periods such as we're going through right now.

We want to thank all of you involved in the leadership of the nursing corps for your service, and look forward to your statement of your accomplishments and the challenges you face. We will be hearing today now from General Gale Pollock, the Chief of the Army Nursing Corps; Admiral Christine Bruzek-Kohler of the Navy Nurse Corps; and General Melissa Rank, the Assistant Surgeon General for Nursing Services for the Air Force.

We welcome you here, want to hear your testimony, and we do have some question.

I turn to my friend, Senator Inouye, to see if he has any opening comment.

Senator INOUYE. Well, I'd like to join you in welcoming these chiefs, but I'd also like to congratulate General Pollock. She did a great job at Tripler. And now you're going to be chief of staff of the Army Medical Command. That's quite an accomplishment. Is this the first time a lady has been in charge?

General POLLOCK. Yes, sir. And the actual job title is—I'll be the deputy surgeon general, sir, not the chief of staff.

Senator INOUYE. That means we're ready for three stars now.

General POLLOCK. I'm not sure the rest of the world's ready for that, sir.

Senator INOUYE. Thank you, Mr. Chairman.

Senator STEVENS. Senator Mikulski, do you have any open comment for the nurses?

Senator MIKULSKI. Well, we're just glad to see you. You know, in every war that America's fought, you've been there, in one way or the other, and we want to make sure that we continue to provide that service. So, we look forward to hearing from you and your ideas and recommendations.

Senator STEVENS. Yes, thank you very much.

General Pollock, we'll hear from you first.

STATEMENT OF MAJOR GENERAL GALE POLLOCK, CHIEF, ARMY NURSE CORPS, DEPARTMENT OF THE ARMY

General POLLOCK. Thank you.

Mr. Chairman and distinguished members of the subcommittee, it's indeed, an honor and great privilege to speak before you on behalf of the nearly 10,000 officers of the Army Nurse Corps.

Army nurses continue making impressive contributions throughout the world. In addition to excellent nursing care of combat casualties, we've provided training for physician and nursing leaders in Afghanistan, served as advisors to the Iraqi armed forces sur-

geon general, and led discussions to raise the quality of military and civilian nursing in the Republic of Vietnam.

Here at home, Army Nurse Corps officers are key to the medical holdover program. Soldiers report high satisfaction and prefer to have Army nurses manage their healthcare. I'm committed to developing a world-class nurse case-management model within the framework of the AMEDD. We expanded the scope of practice for operating room nurses through registered nurse first assist training. This change optimizes the utilization of surgeons, enhancing capabilities in theater and in fixed facilities. Psychiatric advanced-practice nurses are proven force multipliers. I directed that these nurses enroll in psychiatric nurse practitioner programs to clarify the issue of prescriptive authority and provide the Army Medical Department (U.S. Army) (AMEDD) additional flexibility to better support the mental health mission.

Caring for our combat wounded is one of the most demanding services we provide, and we consistently do it well. However, I remain concerned about the toll that caring for these trauma patients exacts over time. The effects of post-traumatic stress disorder and compassion fatigue on our clinicians cannot be underestimated. If left unchecked, it leads to a variety of long-lasting personal and professional problems. It must remain a high-priority issue.

We continue staffing the theater trauma system. Nursing documentation of serious outcomes due to hypothermia resulted in a major change to care on the battlefield and is saving lives.

Army nurse researchers and our doctoral students focus their efforts on military-relevant issues. Recently they examined the physical effects of body armor and loadbearing personal protective equipment, and methods to improve walking performance in amputees. Due to your generous support of the tri-service nursing research program, there is both monetary and educational support for these studies which encourage collaboration and advance the science of nursing practice.

The use of simulators improves the critical thinking and technical skills required of healthcare personnel. The Nursing Science Division of the Army Medical Department (AMEDD) Center and School uses adult and pediatric simulators to augment the training of anesthesia students. The U.S. Army graduate program in anesthesia nursing is the second-ranked program in our Nation, but I remain concerned about the retention of our certified registered nurse anesthetists (CNA).

The need for nurses outpaces the number of new graduates. Baccalaureate programs turn away qualified applicants each year due to faculty shortages. We are encouraging our retiring officers to select faculty positions as a second career.

We learned from Recruiting Command that results were much improved when candidates spoke directly with Army nurses. In response, we launched the every nurse is a recruiter program. Now all nurses are actively engaged in identifying opportunities to recruit and advocate for the highest quality of nursing personnel.

We've received inquiries each year from line officers interested in becoming Army nurses. We're developing a program similar to the Judge Advocate General's funded legal education program to allow them to complete their baccalaureate educations and join us.

In all Army medical treatment facilities, we face significant shortages of civilian nurses, particularly in critical care, postoperative, perioperative, and obstetrics and gynecology (OB/GYN) nursing. The delay of National Student Personnel System (NSPS) renewed our concerns that Office of Personnel Management (OPM) regulations insisting that new college graduates begin their Government service as a GS–5 thwarts our ability to recruit a civilian nursing workforce.

We must be the employer of choice for all professional nurses. Diversified accession and retention incentives for both military and civilian nurses are essential. We will sustain our focus on readiness, clinical competency, and sound educational preparation to serve those who defend our Nation.

PREPARED STATEMENT

I appreciate this opportunity to highlight our accomplishments, and look forward to your questions.

Senator STEVENS. Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF MAJOR GENERAL GALE S. POLLOCK

Mr. Chairman and distinguished members of the committee, it is indeed an honor and great privilege to speak before you on behalf of the nearly 10,000 officers of the Army Nurse Corps. Your unwavering support has enabled Army Nurses, as part of the larger Army Medical Department (AMEDD) team, to provide the highest quality care for our Soldiers and their family members.

I regret that I was unable to be here last year. It was during this time that I co-hosted the 15th Annual Asia Pacific Military Medicine Conference in Hanoi, Vietnam as the U.S. Army Pacific Surgeon, the first international military conference held in Vietnam since the Reunification of Vietnam in the 70's. This forum provides an important cultural exchange for military medical professionals from 27 nations to develop relationships critical to ensuring cooperation and security in the Asia-Pacific region. Several Army Nurse Corps officers from Tripler Army Medical Center also attended, participating in a cultural exchange with Vietnamese military nurses. It is commonly asserted that the unprecedented regional cooperation and response to the devastating tsunami that hit in December 2004 occurred as a result of the relationships previously built at these conferences.

The Army Nurse Corps remains fully engaged in our Nation's defense and in support of its strategic goals. Our vision of advancing professional nursing and maintaining leadership in research, education, and the innovative delivery of healthcare is at the forefront of all we do. Army Nurses provide expert healthcare in every setting in support of the AMEDD mission and the military health system at home and abroad. There are currently almost 400 Army Nurse Corps officers from all three Components deployed in support of operations in 16 countries around the world. From April 2005 to March 2006, we deployed over 500 Army Nurses and mobilized an additional 779 Army Reserve Nurses in support of the total AMEDD mission. They serve in clinical and leadership roles in medical treatment facilities in the United States and abroad, in combat divisions, forward surgical teams, combat stress teams, civil affairs teams, combat support hospitals (CSHs), and coalition headquarters. Today, the 10th CSH from Fort Carson, CO; the 47th CSH from Fort Lewis, WA; and the Army Reserve's 344th CSH from New York are deployed to Iraq. The 14th CSH from Fort Benning, GA is deployed to Afghanistan. The 21st CSH from Fort Hood, TX is expected to arrive in theater by early May to replace the 344th CSH.

The AMEDD team provides the same outstanding care to all, U.S. service members, Iraqi security forces, and civilians of all nationalities. The statistics are astonishing. For example, since November, the 10th CSH has had over 3,500 emergency room visits. Over a quarter were multi-trauma resulting in almost 1,900 admissions, but only one in five were U.S. forces. On the eve of parliamentary elections in Iraq, nurses from the 10th CSH helped deliver the first "democracy baby," a little girl, by cesarean section. LTC Steven Drennan, Chief Nurse of the 10th CSH, recounted several stories of caring for severely wounded Iraqi children as if they were their

own. In summation, he said, "Imagine one of your children in similar circumstances. You'd be overjoyed to know that he was cared for by a staff as concerned, competent, and caring as the Soldiers of the 10th CSH." This is but one unit, one example of our AMEDD team's consistently outstanding performance.

In the wake of Hurricane Katrina, 97 Army Nurses deployed in support of relief operations. The 14th CSH and the 756th Medical Detachment arrived in New Orleans on September 5, 2005. Their initial mission was providing medical relief for those displaced by the storm, but after arrival it changed to providing care for personnel assigned to Joint Task Force (JTF) Katrina. Two of the Army Nurses assigned to the 14th CSH, 1LT Warren Gambino and 1LT Manual Galaviz, had family living in the New Orleans area, making the mission more personal not only for them, but for the entire unit as well. During the deployment, Lieutenant Gambino was promoted from second to first lieutenant in the New Orleans Convention Center. Wearing the only clothes they had, his family was there to witness the event. In mid-October, in preparation for their follow-on deployment to Afghanistan, the 14th CSH transferred authority to the 21st CSH.

The 2005 hurricane season had a huge impact on military installations and personnel across the Gulf Region. Nurses and medics from the 4010th Field Hospital from New Orleans who were serving as backfill at Fort Polk lost family members, homes, and civilian jobs. As part of the Federal Coordinating Center of the National Defense Medical System, William Beaumont Army Medical Center received 65 evacuees from hospitals and nursing homes in Beaumont, TX. At Walter Reed Army Medical Center, the Uniformed Services University of the Health Sciences (USUHS) nurse anesthesia program welcomed Air Force Capt James Goode into their program. Capt Goode, a second year nurse anesthesia student stationed at Keesler Air Force Base, was only months from graduation when the storm hit and he already had orders for Andrews Air Force Base. We worked with the Air Force to get him to Walter Reed where he was able to finish his requirements and graduate on time.

On October 8, 2005, a massive earthquake struck in northern Pakistan. The 212th Mobile Army Surgical Hospital (MASH) was just completing a multinational humanitarian operation in Angola where they treated more than 3,700 patients, performed 191 surgeries, and completed mass casualty, humanitarian assistance, and national disaster response training. By October 25th, the 160th Forward Surgical Team and the 212th MASH, augmented with 11 Army Nurses from the 67th CSH arrived in Pakistan to provide medical relief in the stricken region. During its four months in Pakistan, the 212th MASH, which included 31 Army Nurse Corps officers and 39 enlisted medics, treated over 20,000 outpatients and 838 inpatients, performed 426 surgeries, and responded to 105 life-threatening emergencies—many of which were infants and children. Nurses also accompanied patients on over 250 medical evacuation missions. In February, the 212th, the last remaining MASH in the Army's inventory, turned over the hospital to the Pakistani government. The 212th MASH will be redesignated a combat support hospital in October.

Army Nurses continue making contributions toward building sustainable medical infrastructure throughout the world. Army Nurses assigned to the 14th CSH worked with Afghan officials to spearhead an education outreach program with Afghan nurses. A team, including LTC Susan Anderson and MAJ Brian Benham, provided training for senior Afghan military medical leaders. As part of an effort to improve emergency healthcare in Lebanon, another team led by LTC Kimberly Armstrong conducted basic emergency medical technical training for members of the Lebanese Armed Forces. Eleven Army Reserve Nurses led by COL Cheryl Adams and then COL Gloria Maser were deployed to serve as advisors to the Iraqi Armed Forces Surgeon General. Their efforts resulted in a compendium of basic medical training materials and courses in Arabic, a standardized policy and procedures manual for Iraqi Army medical clinics, and a medical logistics distribution system. They also validated sites and monitored the building progress of 11 medical clinics and a medical supply warehouse. In addition, we sent a team of Army and Air Force nurses to Vietnam to exchange information about military and civilian nursing with representatives from the Republic of Vietnam.

Since 2003, over 20,000 mobilized Army Reserve Soldiers have entered the Army's Medical Holdover Program with injuries and illness due to deployment. With so many Soldiers returning home from theater requiring intensive medical management, there is a tremendous need to assist veterans and their families as they navigate the healthcare system. There are currently 229 mobilized Reserve Army Nurses assigned as case managers throughout the country serving at military medical treatment facilities, mobilization sites, and at eight regional Community-Based Healthcare Organizations. Reports indicated that case managers are effectively and efficiently coordinating appropriate and quality healthcare for this population of ill and injured Soldiers. Soldiers report high satisfaction regarding their case managers

and prefer to have Army Nurses manage their healthcare. I am committed to developing a world-class nurse case management model within the framework of the AMEDD managed care system. Through the efforts of COL Rebecca Baker, we have established authorizations for nurse case managers within Army Reserve medical support units along with the curriculum and qualifications to ensure Reserve nurses who are placed in the case management positions obtain the necessary skills and competencies to manage the healthcare of medical holdover Soldiers.

I am proud of the Army Nurses and our colleagues who have cared for our combat-wounded along the entire medical evacuation pipeline. This is some of the most demanding healthcare anywhere in the world and these wonderful professionals do it consistently well. However, I remain steadfast in my concern about the toll that caring for the traumatically wounded exacts over long periods of time. The effects of post-traumatic stress disorder (PTSD) on clinicians cannot be underestimated. If left unchecked, they can lead to a variety of long-lasting personal and professional problems. The transition to home for healthcare personnel must be as supportive and successful as possible. Facilities have established support groups to assist returning veterans during this critical reintegration time. They have also established programs specifically for clinical staff caring for the combat-wounded to address the issue. These are high-priority issues for us all. We continue searching for new ways to improve the mental health care we provide not only to our returning combat veterans, but also the clinical staff caring for them.

Military medical ethics continues to be a subject of interest for Army Nurses. All professional nurses in the United States abide by the ANA's code of Ethics for Nurses, which clearly states, "The nurse's primary commitment is to the health, well-being, and safety of patients across the life-span and in all settings in which health care needs are addressed." Army Nurses everywhere provide ethical, compassionate, expert nursing care. They receive training in the Geneva Conventions, the Laws of Armed Conflict, and Army Regulations related to the care of detainees. I included deployment ethics in continuing education programs sponsored by the Army Nurse Corps.

As the Army works to rebalance its forces, we are also working to adapt to the circumstances of this long global war on terrorism. We are rapidly applying lessons learned to ensure the best care is provided on the battlefield and across the healthcare spectrum. At the AMEDD Center and School, the Department of Nursing Science has incorporated those lessons into all courses offered to Army Nurses, LPNs, and combat medics. We have had a number of other successes in both ongoing and new initiatives that I would like to share with you.

In wars past, nursing personnel received trauma training on-the-job. Today, we know that the ability to train as interdisciplinary teams under real-world conditions improves patient outcomes. The U.S. Army Trauma Training Center (ATTC) in association with the Ryder Trauma Center, University of Miami/Jackson Memorial Hospital provides our forward surgical teams and slices of CSHs an invaluable opportunity to experience realistic best-practice total team trauma training prior to deployment. We have four Army Nurses and three LPNs on faculty at ATTC. This past year, they trained seven units, including 33 Army Nurses and 19 LPNs to provide state-of-the-art trauma care on the battlefield.

In the absence of real-world training, simulators improve the critical thinking and technical skills required for healthcare personnel. Today, we are not only caring for more patients with lower extremity injuries, but also large numbers of children. To meet that demand, the AMEDD Center and School purchased adult lower body and pediatric simulators to augment the training of nurse anesthesia students learning to employ regional block anesthetics. They also purchased simulators that have true-to-life intravenous access, vital signs, and other capabilities to improve the training medics receive. At the Joint Readiness Training Center, LTC Richard Evans led the effort to incorporate combat trauma simulators into mission rehearsal exercises for CSHs. Using realistic simulators increases the fidelity of pre-deployment training and allows healthcare teams to expertly respond to a combination of live, virtual, and constructive scenarios over time, mirroring military healthcare on the battlefield.

From the beginning of combat operations in Iraq, nurses transported severely wounded patients by air within theater. They performed superbly, but most had no training in aviation medicine. To address this, the U.S. Army School of Aviation Medicine developed the Joint Enroute Care Course to improve medical evacuation care, policy, and coordination. In 2005, the 228th CSH hosted the first iteration in Iraq. Today, with over 40 nurses from all three Services trained, there are fewer issues with patient transports, including accidental line removal and equipment malfunctions. This collaborative joint effort has improved patient care.

The first year of nursing practice sets the foundation for a successful career. We are committed to ensuring that our nurses receive the training and maintain clinical competencies essential in all operational environments. Feedback indicated a need to assist our new nurses in building a firm foundation of clinical competency in critical wartime skills. To address this need, we added the Trauma Nursing Core Course (TNCC) to the Officer Basic Leaders Course in May 2005. Completion of TNCC helps develop core trauma knowledge and critical thinking skills while also establishing a firm foundation in the stabilization of trauma patients. One hundred and thirty three nursing officers successfully completed TNCC in December. This course was coordinated by MAJ Anthony Bohlin with the assistance of Ms. Susan Douglas of the San Antonio Chapter of the Emergency Nurses Association. This was the largest class ever to complete TNCC at one time.

Once new nurses arrive at their first duty station, their initial orientation is critical to proper skill development. We are working towards the creation of an enhanced new graduate internship program. In the meantime, some facilities have relooked at how they orient new graduates. An example is from Tripler Army Medical Center where they provide new nurses opportunities to develop basic competencies in the variety of clinical areas they will experience in a deployed environment rather than focusing on a single competency area.

The Department of Nursing Science at the AMEDD Center and School broke ground for a new general instruction building this past November. The building will be named in honor of Brigadier General Lillian Dunlap, 14th Chief of the Army Nurse Corps, will house all Department of Nursing Science offices, classrooms, and practical exercise areas. We expect it to open in 2007.

The Registered Nurse First Assist (RNFA) is a subspecialty of perioperative nursing offering an expanded scope of practice in the operating room setting. The RNFA practice model expands the scope of practice for perioperative RNs to function as first assists to the surgeons in the operating room and optimizes the utilization of general surgeons. It is also enhances the capabilities of the forward surgical team, the CSH, and fixed facilities. A pilot project at Fort Drum yielded a cost savings of $190,000 by eliminating a costly contract and provided Army Nurses practical experience enhancing wartime capability. Incorporating RNFAs into our structure also enhances our ability to recruit and retain perioperative nurses. Historically, these nurses otherwise looked for advanced training and education in roles unrelated to perioperative nursing within or outside of the Army. In concert with our perioperative nursing consultant, COL Linda Wanzer, USUHS is working to incorporate this training into the curriculum for perioperative clinical nurse specialists. To date, we have trained eight RNFAs and deployed five in support of contingency operations.

Clinical competency is another key concern. We completed a major revision of how our officers who specialize in critical care, emergency, and OB/GYN nursing demonstrate clinical competency. Our goal is to standardize the way in which we confirm and maintain competency for all of our nurses. These revisions clarify guidance on how to achieve this and are particularly important for Army Reserve Nurses who may not practice their military clinical specialty in their civilian employment.

Facilities located on installations with a large number of medical personnel assigned to field units are reestablishing programs to help them maintain clinical competency. We have also begun a number of initiatives in this area with our sister Services. William Beaumont Army Medical Center established a partnership with the medical clinic at Holloman Air Force Base to provide inpatient refresher training for its medical personnel. In the first iteration of a joint critical care nursing course at Fort Sam Houston, we trained eight Air Force critical care nurses. We expect five more to graduate this summer and hope to have five Air Force nurses in the next Emergency Nursing Course. During their deployment in support of JTF-Katrina, members of the 21st CSH completed TNCC, the Combat Lifesaver Course, and the Advanced Cardiac Life Support Course. In Afghanistan, Army Nurses spearheaded an effort that resulted in the 14th CSH's designation as an official provider for the Emergency Medical Technician-Basic (EMT–B) Refresher Course, as well as the Combat Medic Advanced Skills Training Course. Their efforts have helped dozens of combat medics deployed in support of Operation Enduring Freedom sustain critical skills.

Our collaborative efforts also include our colleagues at the Department of Veterans Affairs (VA) and surrounding civilian facilities. Dwight David Eisehower Army Medical Center and the Augusta VA Medical Center established a joint training and staffing initiative which includes a critical care nursing internship program and a staffing pool. Eisenhower, as our lead facility in the Southeast Medical Region, also coordinated with Augusta's Doctors Hospital to provide burn training for

deploying staff and those caring for wounded patients. To date, 50 military and civilian nurses have completed this training.

Many of our smaller facilities serve as clinical training sites for our enlisted medics, such as those in the surgical technologist program. At some of these sites, the caseload was too limited to provide the appropriate clinical experience for our Soldiers. In 2005, we closed 10 sites and shifted our training mission to facilities with larger volumes of diverse surgical cases. This improved the quality of the training students received and better prepared them for deployment.

In June 2005, the family nurse practitioner (FNP) was approved as an authorized substitution for a family physician in CSHs and for physician assistants in division-level units. Deploying FNPs now complete advanced trauma training at the AMEDD Center and School to ensure they are prepared for deployment. We are also collecting lessons learned and actively working with the AMEDD Center and School and USUHS to determine potential opportunities for curriculum changes at each site.

Psychiatric advanced practice nurses are proven force multipliers as authorized substitutions for psychologists on combat stress teams. I am directing officers pursuing graduate education in psychiatric nursing to enroll in psychiatric nurse practitioner (PNP) programs to clarify the issue of prescriptive authority and provide the AMEDD additional flexibility to better support the mental health mission.

Army public health nurses are perfectly suited to meet essential public health demands at home and abroad. As experts in wellness promotion and in building healthy communities, they provide valuable services in a deployed environment and play a key role in the pre- and post-deployment health assessment process. In 2005, we redirected our services toward public health in response to the needs of Soldiers and their families. We realigned the practice of our public health nurses and broadened their roles to include homeland defense, epidemiology, occupational health, and support for national disasters and detainee operations. These changes better position us to meet public health demands in support of our Nation's defense.

The AMEDD's Theater Trauma System Initiative standardizes treatment, evaluates processes, and provides training for clinicians to improve patient survivability in theater. As part of this system, the Joint Theater Trauma Registry systematically collects, stores, and analyzes medical data. We have deployed 12 Army Nurses since 2004 in support of this initiative. The work they do directly improves patient outcomes. For instance, the rate of hypothermia and resulting mortality decreased thanks to the education these nurses provided to first responders and the hypothermia prevention kits they distributed.

Evidenced-based nursing is the process by which nurses utilize research to make clinical decisions and provide state-of-the-art patient care. Army Nurse researchers, in collaboration with their Navy and Air Force colleagues, are heavily vested in the TriService Nursing Research Programs' Center of Excellence in Evidenced-Based Nursing Practice. Projects to bring research findings to the bedside are underway at Walter Reed, Brooke, Madigan, and Tripler Army Medical Centers. These projects are part of a larger effort to improve patient outcomes and reduce costs by standardizing care. They teach nurses how to critique research and incorporate the relevant findings into patient care. Nurses involved in these projects increase their knowledge, become motivated to further their education, and are becoming involved in research projects, much earlier in their careers.

Army Nurse Researchers and our doctoral students focus their efforts on military relevant issues. They are conducting a number of studies that foster excellence and improve the nursing care we provide. They are researching issues including recruit health; clinical knowledge development; the provision of care for the traumatically injured; objectively measuring nursing workload; and the impact of deployments on service members and their families. At USUHS, COL Richard Riccairdi is completing his doctoral dissertation on mitigating the physical effects of body armor and other load-bearing personal protective equipment and LTC Lisa Latendresse is examining how to improve gait and walking performance in amputees.

The Military Nursing Outcomes Database (MilNOD) program of research provides military nurse managers the ability to analyze the effects of staffing patterns on patient safety and outcomes to improve all levels of nursing care. This work builds upon that done by the California Nursing Outcomes Coalition and the Veteran's Administration. Using this framework, nurse managers at the 14 military sites are analyzing workload and staffing data as it relates to patient events and make more informed management decisions. Through your generous support of the TriService Nursing Research Program, there is both monetary and educational support for these studies, which encourage collaboration and advance the science of nursing practice. On behalf of the Army Nurse Corps and the patients whom we serve, thank you.

The U.S. Army Graduate Program in Anesthesia Nursing once again ranks second in the nation. We are equally proud of the USUHS Registered Nurse Anesthesia Program. Our students are actively involved in research studying airway management, hypothermia, herbal remedies, and nurse retention, thus furthering the science of nursing. At Walter Reed, anesthesia students have the additional opportunity to deploy on a two-week humanitarian mission with experienced faculty to obtain field anesthesia experience. Our students are consistently battle ready upon graduation, beginning with board certification. We are proud to say that again this year they had a 100 percent pass rate. Both anesthesia programs produce exceptional graduates who serve our Army and sister Services extremely well.

We acknowledge and appreciate the faculty and staff of the USUHS Graduate School of Nursing for all they do to prepare advanced practice nurses to serve America's Army. They train advanced practice nurses in a multidisciplinary military-unique curriculum that is especially relevant given the current operational environment. Our students are actively engaged in research and the dissemination of nursing knowledge through the publication of journal articles, scientific posters, and national presentations. Of special note, I wish to acknowledge our perioperative clinical nurse specialist students for their contributions to a national white paper on medication errors.

Despite an upswing in enrollments in baccalaureate nursing programs for the fifth straight year, the need for nurses continues to outpace the number of new graduates. Baccalaureate programs continue to turn away tens of thousands of qualified applicants each year, many due to faculty shortages. We remain committed to partnering with the civilian sector to address this and other issues contributing to the worldwide shortage of professional nurses. We are currently researching ways to encourage our retired officers to consider faculty positions as viable second career choices.

The Virtual Clinical Practicum is another example of our efforts to combat the nursing shortage. We first told you about this last year when nurses at Walter Reed Army Medical Center partnered with a rural nursing school to provide their students an effective clinical experience through telehealth technology. Last fall, approximately 180 students from this school participated in the second phase of this study with staff and one enthusiastic patient from the U.S. Army Burn Center in San Antonio. Planning is ongoing for a third practicum. This innovative research initiative is providing tertiary level learning opportunities for students who otherwise would not have that experience.

We have been successful in establishing working relationships with local communities. In Korea, the 18th Medical Command established an exchange for professional nursing with the Korean Ministry of Health. Under this program, four Army Nurses, MAJ Michael Hawkins, MAJ Thomas Cahill, MAJ Dana Munari, and LTC (Ret) Priscilla Quackenbush, were appointed Clinical Professors at Yonsei University where so far they have precepted 26 Korean advanced practice nursing students. At West Point, LTC Diane Scherr is serving as adjunct faculty at Mount Saint Mary's College. Efforts such as these are contributing to a steady supply of basic and advanced practice nurses for the future.

The nursing shortage and current operational conditions continue to make recruitment and retention challenging for all. It is projected that the need for nurses will continue to outpace the supply. The Active Component Army Nurse Corps is short 320 officers. This results in under-filled year groups. Every year since 1999, we have accessed an average of 16 percent fewer officers than required and the projected shortfall for this year is 27 percent. We are also seeing a decline in our retention rates for the first time in many years.

While the Army Reserve is at 100 percent of its authorizations for nurses, each year since 2003, we have accessed an average of 21 percent fewer Army Reserve nurses than required and half of those who were accessed possessed an Associate Degree in Nursing (ADN) or a Diploma in Nursing. However, we still cannot fill crucial company-grade ranks, despite concentrated efforts at recruiting ADN-prepared nurses. This is evidence that simply recruiting more nurses with ADNs is not the answer to solving our shortages in the Reserve Component.

In order to mitigate the current situation, ensure competitive advantage, and build an Army Nurse Corps for the future, we must be the employer of choice for professional nurses. Diversified accession and retention incentives that are attractive to nurses in each sector of the available market are essential. For those sectors which we currently have no recruitment programs, we are collaborating with the U.S. Army Accessions Command to develop relevant recruitment programs that will attract Bachelor of Science prepared nurses to serve in either the Active or Reserve Component. Army Nurses at all levels are actively engaged in the several nurse recruitment and retention programs at our disposal.

We have 47 Army Nurses assigned to recruiting duty. While their efforts are invaluable, we consistently hear that applicants want to talk to Army Nurses directly involved in patient care. In response to this need, we have launched the "Every Nurse is a Recruiter Program" to provide encouragement, opportunities, and recognition for nurses at all levels to become actively engaged in not only the recruitment of Army Nurses, but also the sustainment of professional nursing.

To attract nursing students into the Reserve Officer Training Corps (ROTC), there has to be sufficient financial benefit. We thank the U.S. Army Cadet Command for providing full scholarships and a variety of tools and improved processes to ensure cadets successfully access into the Army Nurse Corps. We also thank Congress for ratifying a limited bonus for ROTC nurse cadets and increasing the cap on ROTC scholarships offered to cadets interested in Reserve Forces duty.

Our AMEDD Enlisted Commissioning Program continues to be extremely successful. This provides Active Component Soldiers $10,000 per year for up to 24 months to complete their BSN while remaining on active duty. We currently start 65 Soldiers per year and hope to expand that in 2007.

We appreciate the efforts of the U.S. Army Recruiting Command (USAREC) to provide the balance of professional nurses we require for the Active Component and all of the nurses for the Army Reserve. They are on the front lines competing with organizations that can often offer more flexible and attractive compensation packages. To help meet our requirements, they have a variety of tools available to help them attract the best-qualified nurses.

For the Active Component, we offer an accession bonus of up to $20,000 and the Health Professional Loan Repayment Program (HPLRP) for up to $30,651. USAREC is able to utilize these tools in various combinations with service obligations to tailor packages to suit individual applicants. This flexibility has proven to be invaluable in today's highly competitive market. Last year, 19 percent of eligible applicants chose the bonus, 27 percent chose loan repayment, and 52 percent opted for a reduced bonus of $8,000 in combination with loan repayment for a six-year obligation. USAREC estimates that without loan repayment, we would have recruited 69 fewer new officers.

In 2005, we reinstated the Army Nurse Candidate Program (ANCP) to target nursing students ineligible to participate in ROTC. ANCP provides a $10,000 bonus and a monthly stipend of $1,000 per month for up to 24 months to full-time students pursing a BSN. To date, we have 12 students enrolled in the program and expect two to access onto active duty this summer.

We receive numerous inquiries from the field each year from Army officers interested in becoming nurses and looking for a program to assist them. In response, we are collaborating with the Office of the Surgeon General and U.S. Army Accessions Command to develop a program that allows them to complete their BSN and convert to Army Nurses, similar to the Judge Advocate General's Funded Legal Education Program for Army lawyers.

For the Army Reserve, USAREC offers an accession bonus up to $30,000 and HPLRP up to $50,000 for selected specialties. Critical care, operating room, psychiatric, and medical-surgical nurses without a BSN can receive an accession bonus of up to $15,000. All Army Reserve accession incentives require a three-year service obligation in the Selected Reserve.

The Specialized Training and Assistance Program for BSN completion (BSN–STRAP) is also now available for both new accessions and existing Army Reserve nurses without a BSN. This stipend program is for those who can complete their BSN in 24 months or less. This is a good start, and I am hopeful that programs to attract BSN-prepared nurses to serve in the Army Reserve will be expanded in the years ahead.

Retention of nurses is of utmost importance. Initial research shows that nurses stay on active duty for the educational opportunities, job satisfaction and retirement benefits. We are proud of the educational benefits we offer our officers. Our graduate-level specialty courses, fully-funded graduate and doctoral education programs, and post-graduate courses are second to none. However, we have five years of data from departing officers that consistently indicates that middle management, lengths of deployment, and the absence of specialty pay are the main reasons they leave. To address this, we are working to refine our retention strategy. In one research effort, we looked at the effect middle managers have on junior staff. The results of this study are being incorporated into our Head Nurse Leadership Course to better educate middle managers on the development of strong and healthy teams.

I am particularly concerned about the retention of our certified registered nurse anesthetists (CRNAs). Our inventory of CRNAs is currently at 73 percent. The restructuring of the incentive special pay program for CRNAs last year, as well as the 180-day deployment rotation policy were good first steps in stemming the loss of

these highly trained providers. We are working closely with the Surgeon General's staff to closely evaluate and adjust rates and policies where needed.

We face significant shortages of civilian RNs and LPNs, particularly in critical care, perioperative, and OB/GYN nursing. We increased utilization of contract support and are currently working on a civilian nurse recruitment and retention program for Walter Reed Army Medical Center and Fort Hood. The AMEDD also recently approved the limited application of a student loan repayment program for current and new civilian nurse recruits.

One promise of the National Security Personnel System (NSPS) is to attract and retain talented and motivated employees. I remain optimistic that NSPS will address the issues that make civil service a disincentive for new and practicing nurses. We have worked with the Navy and Air Force to standardize duty titles throughout the system. This will ease local marketing and facilitate the development of tiers for advanced practice nurses, similar to those for physicians and dentists. However, the delay in implementation of NSPS because of legal challenges by Unions renews our concerns.

The Sustaining Base Leadership and Management Program is a centrally funded leader development program in support of the Army Civilian Training, Education, and Development System (ACTEDS) preparing Army civilian and military members for leadership positions. We actively encourage our civilian staff to take advantage of this training.

The positive impact Army Nurses make on patient care is found throughout the military health system. At Landstuhl Regional Medical Center, CPT Travis Hawksley improved the overall management of burn patients by developing a tool to accurately track fluid resuscitation throughout the evacuation system. Others, such as LTC Sharon Steele and LTC Kris Palaschak provide clinical expertise in the design and construction of new facilities. Our nurse informatacists work to deploy and upgrade electronic clinical systems used to document the delivery of inpatient care, provide objective data related to patient workload, and electronically capture, automate, and analyze patient safety data.

Each year, the Daughters of the American Revolution honor one Active Component Army Nurse who epitomizes professional and military nursing excellence with the presentation of the Dr. Anita Newcomb McGee Award. Last year's recipient was COL Norma Garrett. COL Garret also received the Clinical Nursing Excellence Award from the Association of Military Surgeons of the United States for recognition of her many research accomplishments and contributions to clinical education.

More than ever, the Army Nurse Corps is focused on providing service members and their families the absolute highest quality care they need and deserve. We continue adapting to the new realities of this long war, but remain firm on providing the leadership and scholarship required to advance the practice of professional nursing. We will maintain our focus on sustaining readiness, clinical competency, and sound educational preparation with the same commitment to serve those Service members who defend our Nation that we have demonstrated for the past 105 years. I appreciate this opportunity to highlight our accomplishments and discuss the issues we face. Thank you for your support of the Army Nurse Corps.

BIOGRAPHICAL SKETCH OF MAJOR GENERAL GALE S. POLLOCK

MG Gale S. Pollock was born in Kearny, New Jersey, but calls Texas home. She holds a Bachelor of Science degree in nursing from the University of Maryland and is a 1979 graduate of the U.S. Army Nurse Anesthesia Program. She earned a Master of Business Administration from Boston University; a Master in Healthcare Administration from Baylor University; and a Master in National Security and Strategy from the National Defense University. Her military education includes completion of the General Officer Joint CAPSTONE program; Senior Service College at the Industrial College of the Armed Forces; the U.S. Air Force War College; the Interagency Institute for Federal Health Care Executives; the Military Health System CAPSTONE program; the Principles of Advanced Nurse Administrators; and the NATO Staff Officer Course.

In addition to her responsibilities as the 22nd Chief of the Army Nurse Corps, MG Pollock is currently the Commander of Tripler Army Medical Center and the Pacific Region, U.S. Army Pacific Surgeon and the Multi Market manager under the regional TRICARE program. Her past military assignments include Special Assistant to the Surgeon General for Information Management and Health Policy; Commander, Martin Army Community Hospital, Fort Benning, GA; Commander, U.S. Army Medical Department Activity, Fort Drum, NY; Staff Officer, Strategic Initiatives Command Group for the Army Surgeon General; Department of Defense

(DOD) Healthcare Advisor to the Congressional Commission on Service Members and Veterans Transition Assistance; Health Fitness Advisor at the National Defense University; Senior Policy Analyst in DOD Health Affairs; and Chief, Anesthesia Nursing Service at Walter Reed Army Medical Center, Washington, DC.

MG Pollock's awards and decorations include the Legion of Merit (with two Oak Leaf Clusters), the Defense Meritorious Service Medal, the Meritorious Service Medal (with three Oak Leaf Clusters), the Joint Service Commendation Medal, the Army Commendation Medal, and the Army Achievement Medal. She proudly earned the Expert Field Medic Badge and the Parachutist Badge. She received the Army Staff Identification Badge for her work at the Pentagon. In addition, she earned the German Armed Forces Military Efficiency Badge, "Leistungsabzeichen", in gold.

Senator STEVENS. Admiral, we'd be pleased to have your statement.

STATEMENT OF REAR ADMIRAL CHRISTINE M. BRUZEK-KOHLER, DIRECTOR, NAVY NURSE CORPS, DEPARTMENT OF THE NAVY

Admiral BRUZEK-KOHLER. Thank you.

Good morning, Chairman Stevens, Senator Inouye, and distinguished members of the subcommittee.

I am Rear Admiral Christine Bruzek-Kohler, the 21st Director of the Navy Nurse Corps and the Navy Medical Inspector General. It is an honor and a privilege to speak before you about our outstanding 4,500 Active and Reserve Navy nurses and their contributions in operational, humanitarian, and traditional missions at the home front and abroad.

My written statement has already been submitted for the record, and I would like to highlight a few key issues.

In this time of increased deployments, our Navy nurses are utilizing their specialized training in critical wartime specialties everywhere in the continuum of care, from the battlefield, with our forward-deployed troops, to our military treatment facilities, for restorative and rehabilitative care.

In the last year, they have served with distinction in a variety of locations—Kuwait, Iraq, Djibouti, Afghanistan, Bahrain, Qatar, Thailand, Indonesia, Sri Lanka, New Guinea, Pakistan, Guantanamo Bay, Cuba, and along our own gulf coast to provide assistance to Hurricanes Katrina and Rita victims. As part of the Marine Corps team, our perioperative critical care and anesthesia nurses in the forward resuscitative surgical system, shock trauma platoons, and en route care system are influencing the survivability of our battlefield casualties. With the prevalence of combat and operational stress, mental health nurses are part of the collaborative treatment team providing immediate interventions at the front and post-deployment.

At Naval Medical Center San Diego, one of our nurse leaders is spearheading a multidisciplinary team to establish the Comprehensive Combat Casualty Care Center. This is a patient- and family-centered cooperative program with the San Diego VA Medical Center to provide the full spectrum of care to our returning casualties and their families.

During 2005, our hospital ships, U.S.N.S. *Mercy* and U.S.N.S. *Comfort*, were providing care for natural disaster victims overseas and along the gulf coast. Both of our hospital ships recently deployed, last week. While the U.S.N.S. *Comfort* is involved in a joint exercise with the Canadian Government, our nurses are optimizing this training opportunity to enhance their clinical skills in response

to regional and domestic emergencies. Simultaneously, the U.S.N.S. *Mercy* is partnering with volunteer nurses from nongovernmental organizations and host nations in a transcultural nursing effort to share clinical skills while providing quality care during humanitarian missions in Southeast Asia.

This increased operating tempo (OPTEMPO) underscores the necessity for clinical skills sustainment through operational and joint training programs such as the Defense Medical Readiness Training Institute for burn and trauma care and the Army enroute care course at Fort Rucker, Alabama, for medical evacuation. Through written agreements, we have also collaborated with civilian medical communities for training in intensive care, emergency, and other specialty areas.

In the face of a national nursing shortage and the challenges we have had in recruiting over the past 2 years, we have implemented several initiatives to attain our recruiting goal this year. We have seen more applications as a result of the tiered-rate increase of our nurse corps accession bonus at $15,000 for a 3-year and $20,000 for a 4-year obligation. For the first time, we offered the health professions loan repayment program, up to $30,000 for school loans, with all positions filled. We have also increased the accession bonus from $5,000 to $10,000, and stipend from $500 to $1,000, for the nurse corps candidate program, as well as increasing our recruitment goals for this program by 20 nursing students, for a total of 75.

Retention of Active duty nurse corps officers has posed a greater challenge. Our present manning end strength is at 92 percent in the Active component. As a retention tool, the health professions loan repayment program was also offered for all eligible Navy nurses. The certified register nurse anesthesia incentive special pay was increased along tiered levels from $20,000 to $40,000, with a 1-to-4-year obligation. In addition, we are exploring other incentives to retain our junior nurse corps officers after 4 years of service.

In the Reserve component, our critical wartime specialties in mental health nursing, perioperative nursing, and nurse anesthesia pose recruitment challenges. For that reason, fiscal year 2006 nurse accession bonuses are targeted toward these specialties. With our increased rate of mobilization to Kuwait and to our military treatment facilities, it is imperative that we meet our nursing specialty requirements and explore all options to support our recruitment and retention efforts.

Civil Service nurses are the backbone of professional nursing practice in our military treatment facilities. To remain competitive during this national nursing shortage, we implemented the special salary pay rates granted under title 38 at five military treatment facilities. We also implemented the accelerated promotion program at Naval Medical Center San Diego to recruit recent nursing school graduates. Our robust graduation—our graduate education program is one of our top retention initiatives. On an annual basis, we select our most talented nurse leaders to attend accredited universities around the country. They attain their master's and doctorate degrees in our required specialties to meet our mission.

Our focus on military nursing research is key to successful patient outcomes and quality care, and we do appreciate the support of the tri-service nursing research program in this effort. As a result, we have been able to incorporate evidenced-based clinical-practice guidelines and multisite protocols. Some examples are programs in pain and wound management, falls precaution, and prevention of nosocomial infections. Our innovative practices and research findings involving care from the battlefield to our military treatment facilities are cited in numerous professional publications and textbooks. Navy nurses have also shared their expertise, their presentations at national and international healthcare forums.

PREPARED STATEMENT

In summary, from World War I to the present global war on terrorism, Active and Reserve Navy nurses have answered the call of a grateful Nation and created a legacy for all of us. In the tradition of nursing excellence, our nurses are providing the finest care worldwide, making a positive and meaningful difference in the lives of our sailors, marines, their dependents, and our retired heroes. I appreciate the opportunity of sharing the accomplishments and issues that face Navy nursing. I look forward very much to working with you during my tenure as director of the Navy Nurse Corps.

Thank you.

Senator STEVENS. Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF REAR ADMIRAL CHRISTINE M. BRUZEK-KOHLER

Good morning, Chairman Stevens, Senator Inouye and distinguished members of the Committee. I am Rear Admiral Christine Bruzek-Kohler, the 21st Director of the Navy Nurse Corps and the Naval Medical Inspector General. It is an honor and privilege to speak before you about our outstanding 4,500 Active and Reserve Navy Nurses and their contributions in operational, humanitarian and traditional missions at the home front and abroad. We have had many challenges facing us over the past year including the continuing War in Iraq, the Global War on Terrorism and the recent devastation of Hurricanes Katrina and Rita. Based on the magnificent performance of our Navy Nurses answering the call to duty at a moment's notice and the support of our outstanding Civil Service and contract nurses, I am confident that we successfully meet all challenges with commitment and dedication while providing hope and comfort to all those in need.

The future success of the Navy Nurse Corps depends on our ability to clearly articulate our military relevance and alignment with the goals of the Navy and Navy Medicine. To accomplish this, our nurse leaders recently met to review our strategic goals and objectives in 2005 and determine where we need to be in 2006 and beyond. The outcome of this meeting resulted in the establishment of five priorities for Navy Nursing, specifically aligned with the vision and goals of the Chief of Naval Operations and our Surgeon General. To chart our course and navigate our achievements into the future, these five priorities include: emphasis on clinical proficiency to sustain our readiness; validation of Nurse Corps requirements and force shaping; review of the processes to match educational opportunities to requirements; improved management and leadership development for mid-level Nurse Corps officers; and a formalized leadership continuum for senior Nurse Corps officers entering executive level positions. Addressing each category, I will highlight our achievements and issues of concern.

READINESS AND CLINICAL PROFICIENCY

Throughout the career continuum, all Navy Nurses must be responsive, capable and continually ready to maintain mission essentiality. We must be clinically proficient to quickly deploy, arrive on the scene whether it is New Orleans or Baghdad, and deliver the finest nursing care. Solid clinical competencies ranging from the fun-

damentals to specific wartime specialties serve as the foundation to enhance the depth and quality of nursing care in all environments. To meet these challenges, we remain on the cutting edge of clinical nursing to provide the finest care to our Sailors and Marines, while welcoming opportunities to participate in a joint service environment.

During the past year, Navy Nurses from both active and reserve components were deployed throughout the world as members of joint, multi-national, Marine Corps and Navy missions, recording over 60,000 days in support of and training for our missions. Operational units were located in Kuwait, Iraq, Djibouti, Afghanistan, Bahrain, Qatar, Thailand, Indonesia, Sri Lanka, New Guinea, Pakistan, Guantanamo Bay, Cuba and along our own Gulf Coast to provide assistance to Hurricanes Katrina and Rita victims. Nursing care services for both operational and humanitarian missions were delivered by Surgical Teams, U.S. Marine Corps Surgical Companies, Shock Trauma Platoons, and the Forward Resuscitative Surgical Systems, including the Enroute Care System Teams for casualty evacuation. In addition, care was provided in Expeditionary Medical Facilities; on Navy and Hospital ships including aircraft carriers; and at our military treatment facilities.

Ultimately supporting warfighting capability, Navy Nurses are at the front, developing and implementing numerous health care programs to assist active duty personnel and their families. With the prevalence of combat and operational stress, mental health nurses are providing immediate interventions at the front, assisting our troops to cope; through humanitarian missions, providing aid to natural disaster victims; and to our military treatment facilities, enhancing access to care for our military personnel and their families. Through the Medical Rehabilitation Platoon Program at Camp Geiger, North Carolina, nurses have closely coordinated the medical care of our Marines, decreasing their length of stay in the program and increasing their timely return to full duty for training. As active participants in Operation Special Delivery at Twenty-Nine Palms, California, nurses received Honorable Mention through the Admiral Thompson Awards Program for Community Relations. As trained doulas, they provide physical, emotional and information support to women with deployed spouses before, during and after childbirth. Partnering with volunteer Project Hope nurses, our Navy Nurses of all specialties assisted devastated Americans along the Gulf Coast and onboard the Hospital Ship Comfort, providing the best quality of care with pride. The most noteworthy accomplishments included providing emergency trauma care, completing over 900 screenings for trauma indicators and crisis management; implementing preventive mental health interventions for local relief workers; and establishing a Mother Baby Unit.

Our nurses continuously seek specialized training to enhance their critical wartime nursing specialties to safely administer immediate and emergent care in any situation. To provide comprehensive care for our trauma casualties, Navy Nurses have maximized available training opportunities through the Navy Trauma Training Course at the Los Angeles County/University of Southern California Medical Center with their operational platform team members; the Tri-service Combat Casualty Course in San Antonio, Texas for all nurses; and the Military Contingency Medicine/Bushmaster Course for our students at the Uniformed Services University Graduate School of Nursing in Bethesda, Maryland.

Joint training opportunities in critical wartime nursing specialties in both military and civilian medical communities are essential to enhance our mission-ready capabilities. Navy Nurses in Guam, Marianas Island have rendered assistance to Air Force nurses in maintaining their critical readiness skills. In return, our nurses have attended the Air Force Critical Care Air Transport Team Training in San Antonio, Texas to optimize medical evacuation efforts. Coordinating with Landstuhl Regional Medical Center in Germany, our nurses from Naples, Italy have been able to enhance their clinical skills in emergency room, critical care, advanced medical-surgical and complicated obstetrics. Our nurses in Yokosuka, Japan have invited the Japanese Self Defense Force nurses to their Trauma Nurse Core Courses, fostering goodwill relationships. Supporting the concept of interoperability, Navy Nurses in the reserve component have worked seamlessly with the Defense Medical Readiness Training Institute, sponsoring and teaching three professional programs pertaining to trauma. A total of 50 courses in Advanced Burn Life Support, Combat Trauma Nurse Curriculum and Pre-Hospital Trauma Life Support were conducted on-site at San Antonio, Texas and exported to several regional training sites to maximize participation, such as in Camp Pendleton, California; Great Lakes, Illinois; Dallas, Texas; and Fort Gordon, Georgia.

Within and across our military treatment facilities, we optimize all cross-training opportunities to maintain clinical proficiency for our operational assignments. We continue with robust Nurse Internship Programs at our three Medical Centers at Bethesda, Maryland; Portsmouth, Virginia; and San Diego, California. With the re-

turn of Sailors and Marines from Iraq with complicated trauma wounds, we have focused more intensive training to become certified wound care specialists. Aligned with professional standards of practice, we have adopted the Essentials of Critical Care Orientation by the American Association of Critical Care Nurses as our primary didactic critical care training curriculum, augmented with on-site clinical rotations at our larger military treatment facilities. The successful Post Anesthesia Care Course at Bethesda, Maryland has included a total of 30 Army and Air Force nurses and medics in addition to Navy personnel in the past year, and has been exported to other Navy military treatment facilities due to its strong clinical content and application.

Collaborating with our civilian medical communities, our nurses in Jacksonville, Florida maintain an agreement with Shands Medical Center to train in their intensive care unit, emergency room and neonatal ward. In addition, at the Medical University of South Carolina, our nurses in Charleston participate in a two-week trauma orientation to sustain their clinical readiness. In our outreach support of community education, we have provided clinical experiences and preceptors to nursing programs throughout the United States. We have also participated in collaborative training groups, such as the Greater Washington Area Consortium for Critical Care Nursing Education. These examples are only a few of the many courses and training sessions taking place on a regular basis to maintain clinical proficiency and optimize operational readiness.

REQUIREMENTS AND FORCE SHAPING

Maintaining the right force structure is essential in meeting Navy Medicine's overall mission through validated nursing specialty requirements, utilizing the talent and clinical expertise of our uniformed and civilian nurses. Focused on our operational missions, our wartime specialties include nurse anesthesia, critical care, emergency, mental health, medical-surgical and perioperative nursing.

The national nursing shortage, compounded by competition with civilian institutions as well as other federal sectors, has resulted in direct accession recruiting shortfalls over the last two years. For that reason, we continue to closely monitor the status of our pipeline scholarship programs, which include the Nurse Candidate Program, the Medical Enlisted Commission Program, the Naval Reserve Officer Training Corps Program, and the Seaman to Admiral Program. Rate increases were applied this fiscal year to our Nurse Corps Accession Bonus to attract new applicants to the naval service. In addition to increasing the accession bonus and stipend for the Nurse Candidate Program, we have recently increased our recruitment goals for this program by 20 nursing students.

Retention of active duty Nurse Corps officers has posed a bigger challenge, with retention rates after the first four years of commissioned service ranging from 54 to 72 percent for all accession categories and decreasing further beyond 4 to 7 years of service. At the end of calendar year 2005, our manning end strength decreased to 94 percent in the active component, with a deficit of 175 Navy Nurses. Within our wartime specialties, shortfalls have been identified in critical care with an end strength of 57 percent, nurse anesthesia at 84 percent and perioperative nursing at 90 percent. To counter these deficiencies, the Health Professions Loan Repayment Program was recently implemented for recruitment and retention purposes. In addition, the Certified Registered Nurse Anesthesia Incentive Special Pay was increased. We will continue to closely monitor our end strength through the year, evaluate newly initiated programs and explore other options to retain our talent at the 4 to 10 years of service level.

In the reserve component, our critical wartime specialties also pose a recruitment and retention challenge in mental health nursing, perioperative nursing and nurse anesthesia. For that reason, fiscal year 2006 Nurse Accession Bonuses are focused on these specialties. We had a record of success during the past fiscal year with the Nurse Accession Bonus when it was offered for the first time to professional nurses with less than one year of experience. Since there is a national nursing shortage of perioperative nurses, our six-week perioperative nursing training programs in Jacksonville, Florida and Camp Pendleton, California now include our reserve nurses. As a pipeline program, our Hospital Corpsman to Bachelor of Science in Nursing Program has resulted in three Nurse Corps Officers entering the reserves since its inception two years ago, with twenty-three participants who will graduate within the next one to two years. With our increased rate of mobilization to Kuwait and to our military treatment facilities, it is imperative that we meet our nursing specialty requirements and explore all options to support our recruitment and retention efforts.

Civil Service nurses are the backbone of professional nursing practice in our military treatment facilities as the frequency of deployment schedules increases for our uniformed personnel. We continue to encourage the use of authorized compensation packages to retain our talented nurses through recruitment, retention and/or relocation bonuses to meet staffing requirements. Last year, we implemented Special Salary Pay rates granted under Title 38 at five military treatment facilities in San Diego, California; Camp Pendleton, California; Twenty-Nine Palms, California; Great Lakes, Illinois; and Bethesda, Maryland to compensate for on-call, weekend, holiday, and shift differential duty, resulting in satisfaction to staff members and leadership. In addition, we have recently implemented the Accelerated Promotion Program in San Diego, California to recruit novice nurses with less than one year of experience, who have been integrated into their Nurse Internship Program to develop solid clinical skills.

Our success in meeting the mission in all care environments requires that we continuously reassess our measures of effectiveness, adjust personnel assignments, transfer authorized billets, and revise training plans. To maximize our performance, it is imperative that we pursue funding to recruit and retain our exceptionally talented nurses to meet our staffing requirements. We will also closely monitor the national nursing shortage projections and the civilian and federal compensation packages to determine the best course for us to take in this competitive market.

EDUCATION PROGRAMS AND POLICIES

The Navy Nurse Corps provides state-of-the-art nursing care around the world, 365 days a year by continually adapting to the ever-changing healthcare environment. We accomplish this by maintaining our competitive edge beyond the status quo through a variety of initiatives. On an annual basis, we shape our graduate education training plan based on our health care and operational support requirements. We select our most talented nurse leaders to attend accredited universities around the country to attain their masters and doctorate degrees, which has also proven to be an invaluable retention tool. In addition, a plethora of continuing education courses and specialized training opportunities are available to further enhance solid clinical skills.

The success of our graduate education and specialized training is exemplified through the remarkable impact of our professional achievements in Navy Medicine and across the Department of Defense. Our advance practice nurses lead the way in building upon our reputation of outstanding patient care by incorporating evidence-based clinical practice guidelines and multi-site protocols to improve patient outcomes. Through the Evidence-Based Consortium developed by nurses from Bethesda, Maryland, and Portsmouth, Virginia with Walter Reed Army Medical Center, team training has resulted in a focus on primary surgical wound dressings, alcohol withdrawal assessment and peripheral intravenous therapy. In collaboration with the Washington State Hospital Association as part of Institute for Health Care Improvement initiatives, our nurses in Bremerton, Washington have participated in the implementation of three clinical practice guideline protocols: elimination of nosocomial infections, prevention of ventilator associated pneumonia and prevention of central line infections. Each protocol consists of a group of interventions resulting in better outcomes, a reduction in mortality, and cost containment. Nurses at Bethesda, Maryland are involved in a TRI-STATE initiative implementing similar protocols, in addition to the Critical Care clinical practice guideline. Through the Pain Management Clinic at Jacksonville, Florida, civilian referrals have been reduced and patient satisfaction increased, resulting in significant cost avoidance.

The focus on military nursing research is essential to successful patient outcomes and quality care. Sponsored by the TriService Nursing Research Program, the collaborative multi-phase Evidence Based Practice Improvement Project between National Naval Medical Center and Walter Reed Army Medical Center plans to implement six nursing practice guidelines at each site. Our Navy Nurses have developed guidelines for pain management, falls prevention and neonatal tactile stimulation and thermoregulation. A sample of funded research studies includes: Retention of Recalled Navy Nurse Reservists Following Operation Iraqi Freedom; Oxidative Stress and Pulmonary Injury in U.S. Navy Divers; Coping Interventions for Children of Deployed Parents; and Focused Integrative Coping Strategies for Sailors, a Follow-Up Intervention Study.

There have been numerous publications attesting to the expertise of our Navy Nurses, such as in Advances of Neonatal Care, Archives of Psychiatric Nursing, Association of Operating Room Nurses Magazine, Journal of Cardiac Failure and professional textbooks. In addition, Navy Nurses have been invited to present innovative practice and research findings at Sigma Theta Tau Nursing Honor Society's

International Nursing Research Congress; the Annual Meeting of the Association of Military Surgeons of the United States; the 18th Annual Pacific Research Conference, and many more. Of prestigious note, two of our Navy Nurses were invited to coordinate and present a symposium entitled "Military Nursing Care: Land, on the Sea and in the Air" with Army and Air Force colleagues at the Biennium Conference for Sigma Theta Tau International focusing on burn care, quality of life and nursing care delivered in austere environments.

It is this personal dedication to the highest clinical proficiency and continuing education that makes us proud members of the military healthcare system today and tomorrow. As the scope and practice of nursing continues to grow, we must make sure that we continue to be closely aligned with Navy Medicine and the Line community.

MID-LEVEL LEADERSHIP/SENIOR LEADERSHIP DEVELOPMENT

The last two priorities consist of improving management and leadership development for mid-level Nurse Corps officers and formalizing the leadership continuum for senior Nurse Corps officers entering executive level positions. Leadership development begins the day our nurses take the commissioning oath as Naval Officers and is continuously refined throughout an individual's career with increased scope of responsibilities, upward mobility, and pivotal leadership roles within the field of nursing and health care in general. Our Navy Nurses are proven strategic leaders in the field of education, research, clinical performance, and health care executive management. To insure we continue this legacy of nursing excellence, it is critical that we identify those leadership characteristics and associated knowledge, skills and abilities that are directly linked to successful executives in Navy Medicine. This information will provide the basis for ongoing leadership development of our mid-grade officers as they advance in their leadership and management positions and experiences.

To meet today's challenges, nurse leaders must be visionary, innovative and actively engaged across joint service and interagency levels to maximize our medical capabilities and achieve new heights of excellence. As one of many examples, a Navy Nurse recently assumed command of the Expeditionary Military Facility at Kuwait, which is comprised of personnel from 22 Navy Medical Commands. Navy Medicine Emergency Management Program nurses are developing a comprehensive strategy to guide our efforts to prevent or deter health consequences of natural or international attacks. Navy Nurses are involved in the multi-faceted development of a Federal Health Care Facility as part of the Veterans Affairs/Department of Defense partnering project. Within the Reserve Component, our dedicated Navy Nurses are in key leadership positions in their units, as well as in their civilian organizations, professional associations and local communities. Of particular note, our nurse leaders in the Navy Reserve Operational Health Support Unit at Jacksonville, Florida attended training at the Air National Guard's Mentoring Conference, prior to developing and coordinating the Navy's Mentoring Initiative. Effective partnerships have resulted in positive mentoring experiences between junior and senior officers, promotions, advancement to leadership positions, and professional development.

CLOSING REMARKS

From World War I to the present War on Terrorism, active and reserve Navy Nurses have answered the call of a grateful nation and created a legacy for all of us. As we near the 100th anniversary of the Navy Nurse Corps, we are most proud of being integral members of the One Navy Medicine Team through an outstanding record of partnering with civilian and military health care teams, ensuring a better tomorrow for all. Our nurses provide the finest care worldwide and make a positive and meaningful difference in the lives of our Sailors, Marines, their dependents and our retired heroes. The basis of our future requires that we align with the mission of our armed forces while adapting to the advances in professional nursing practice. The uniqueness of military nursing is our dynamic ability to seamlessly integrate the critical nursing specialties into the personal needs of the troops on the field and at sea. Indeed, we will continue the exemplary tradition of Navy Nursing Excellence by focusing on interoperability and working side by side with colleagues from each service with personal pride.

I appreciate the opportunity of sharing the accomplishments and issues that face Navy Nursing. I look forward to working with you during my tenure as Director of the Navy Nurse Corps.

Senator STEVENS. General Rank.

STATEMENT OF MAJOR GENERAL MELISSA A. RANK, ASSISTANT SURGEON GENERAL FOR NURSING SERVICES, DEPARTMENT OF THE AIR FORCE

General RANK. Mr. Chairman and distinguished Members of the subcommittee, it is truly my honor to represent the Active duty, Guard, Reserve, and civilian nurses and medical technicians of the United States Air Force total nursing force. This diverse group of professionals partner with the Air Force Medical Service to ensure a fit and healthy force, prevent casualties, restore health, and enhance human performance.

I have personally contacted every Active duty chief nurse and senior medical technician and asked them, "What keeps you up at night?" Their predominant concerns validated my vision to strengthen operational currency and clinical expertise. Today, I will share with you our successes and challenges in expeditionary nursing, clinical skills sustainment, recruiting and retention, research, and future initiatives.

Over the past year, our responsiveness was put to the test and was highly successful in the U.S. Central Command's Area of Responsibility and at home station. We are trained, current, and mobile. Our primary contributions to expeditionary operations are lifesaving medical/surgery and critical-care skills, and aeromedical evacuation. Even greater strides have been made ramping up from home station to war front. We credit this to our current inpatient experiences and continuous improvements in predeployment training. We deploy 2,369 total force nursing service personnel to five aeromedical evacuation locations, 10 expeditionary medical support units, and two contingency aeromedical staging facilities (CASF). Total patients evacuated from theater in support of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) were 33,615 from October 10, 2001 to April 14, 2006. Of that total, over 6,200 were due to battle injuries. Key in the clinical transformation of our aeromedical evacuation system was the shift from transporting stable patients to rapidly moving patients requiring continuous in-flight stabilization, putting critical care nurses in very high demand. Our highly specialized critical care air-transport teams moved 711 critically ill patients last year.

The expeditionary medical group at Balad is currently home to 69 nurses and 97 medical technicians from our total force, the Army, and multinational forces. Nine different surgical specialties are on hand to provide state-of-the-art treatment, including care of massive trauma.

The CASF at Ramstein Air Base safely moved over 15,000 patients to Landstuhl Regional Medical Center. Time and again, the heroic efforts of the integrated healthcare team at Landstuhl came together to save the lives of wounded Americans, coalition forces, DOD contractors, and members of the press corps.

The best way for nurses to maintain currency and be effective in deployed settings is to have recent hands-on experience as inpatient nurses. Recently, I released a policy mandating that nurses working in outpatient and nonclinical roles will complete a minimum of 168 hours on inpatient units annually. Bringing seasoned clinicians back to the bedside will provide a robust, technically ready force and mentorship to the less experienced.

Due to unique deployment missions, we are increasingly using the Center for Sustainment of Trauma and Readiness Skills Training Platform (C–STARS). C–STARS produces medics ready to respond to peacetime or wartime contingencies through intense clinical immersion. The USUHS Graduate School of Nursing incorporated "go to war" skillsets into the curriculum for advanced practice nurses.

At home, Hurricanes Katrina and Rita uniquely challenged our total force. Aeromedical evacuation crews and Expeditionary Medical Support (EMEDS) teams from Active duty, Guard, and Reserve safely moved over 2,600 patients after Katrina, and over 1,200 patients before Rita made landfall. Keesler Medical Center was greatly impacted by Katrina. Their staff saved 130,000 medical records, erected an EMEDs, accounted for personnel, built new staffing requirements, and reopened limited primary care services in less than 1 month after the hurricane.

Nursing is globally engaged, at stateside and overseas locations. Independent-duty medical technicians, Technical Sergeant Steven Yates and Technical Sergeant John Strothenke, from Alaska, deployed in support of the Joint Prisoners of War/Missing in Action (POW/MIA) Account Command Mission, which recovered the remains of 19 service members in last calendar year.

Through the international health specialist program, we gained access to countries that are otherwise inaccessible. Major Stephanie Buffet, currently working for the U.S. Central Command (CENTCOM) surgeon, played a pivotal role in the Air Force's response to medical issues in the ongoing Pakistan earthquake relief efforts.

Continuous global engagement is making recruiting and retaining nurses one of our top priorities, especially with the national nursing shortage. Our accession sources include direct accession, Reserve Officers' Training Corps (ROTC) scholarship, health profession scholarship program, and enlisted to Bachelor of Science in Nursing (BSN) programs. In fiscal year 2005, we assessed 69 percent of our total recruiting goal of 357. Direct accessions, accounting for 82 percent took advantage of the recruiting bonus or the loan repayment program, and will increase for fiscal year 2006. And we thank you.

We are investigating a robust nurse enlisted commissioning program, mirroring the Navy's success, to produce 50 officers from our enlisted force, allowing them to attend accredited bachelor's or entry-level master's programs. In fiscal year 2005, our nurse corps inventory was at 90 percent of authorized positions. Currently, our inventory is a concerning 87 percent.

We continue to monitor our attrition rates, particularly those at the first decision point at the completion of initial obligated service—4 years of commissioned service. To ensure we retain those experienced nurses, we plan to offer a critical skills retention bonus near the end of their initial commitment. We are also partnering with our sister services and Veterans Administration (VA) counterparts to expand training platforms.

In addition to financial and training incentives, the quality of our medical treatment facilities is clearly of importance to recruiting and retaining top professionals. Sustaining state-of-the-art infra-

structure is a top priority for maximizing clinical and operational effectiveness and promoting a safe environment for both staff and patients.

Air Force nurses continue to remain at the forefront of operational research. Crucial areas being examined include deployment health, sustaining competencies, military practice outcomes, recruitment, and retention. None of this would be possible without the enormous support from the tri-service nursing research program, that will have far-reaching implications for our military forces.

Several major events continue to shape our future. The Air Force transitioned to an expeditionary mission, and now deliberately prepares airmen through aggressive force development policies and programs. Through a comprehensive review of the medical group structure, we developed a new flight path to guide our organizational structure and the development of our clinical discipline. The flight path guides more deliberate development, placing the member in the right job at the right time, setting them up for career success and personal satisfaction, while maintaining expertise at the front lines of patient care.

Nursing is already preparing for the many BRAC-related challenges by finding alternative inpatient platforms to train and sustain personnel, and by determining the right composition of Active duty "blue suit", requirements. We continue to evaluate our deployment-drive requirements and use market availability, along with cost data, to recommend appropriate civilian conversions. We plan to target company-grade outpatient and maternal childcare positions, while maintaining Active duty nurses for inpatient platforms. Along these lines, the results of the 2001 Air Force Surgeon General directed Nurse Corps Topdown Grade Review continues to guide our actions, and we strive to balance our company- and field-grade authorizations. We remain optimistic that our course of action will help improve overall promotion opportunity; therefore, increasing retention of experienced nurses. We've successfully increased field-grade requirements for deployment positions and are taking steps to lay in more senior clinicians at home station.

Mr. Chairman and distinguished members of the subcommittee, it is an honor and a privilege to lead the men and women of our Active, Reserve, and Guard nursing services. My objective for this presentation was to provide you a glimpse of the extraordinary men and women that make up nursing services and the exceptional work they are doing daily in the service of their country. I look to the future optimistically and desire your continued support during these exciting times ahead for nursing and our Air Force.

PREPARED STATEMENT

Thank you for inviting me and allowing me to tell our story.

[The statement follows:]

PREPARED STATEMENT OF MAJOR GENERAL MELISSA A. RANK

Mr. Chairman and distinguished members of the committee, it is truly an honor for me to be here for the first time representing Air Force Nursing Services. We employ a diverse group of professionals to ensure a fit and healthy force, prevent casualties, restore health, and enhance human performance.

The vision for my tenure is to strengthen operational nursing currency and clinical expertise. The Air Force Nurse Corps will focus on our continued development as a clinical discipline to sustain nurses and aerospace medical technicians in an ever-changing, joint interoperable environment.

EXPEDITIONARY NURSING

Our expeditionary medical capability has been proven and Air Force Nursing Services remains in the forefront supporting the war fighter. Globally since the year 2000, we supported 202 worldwide missions and exercises, treated 1.47 million patients, assisted with 2,700 surgeries, and helped train 4,200 foreign medics. Just this past year, we deployed 2,369 nursing service personnel in support of Operations ENDURING FREEDOM and IRAQI FREEDOM (OEF/OIF). These Total Nursing Force members from the Active Duty (AD), Air National Guard (ANG), and Air Force Reserve Command (AFRC) deployed in support of 5 Aeromedical Evacuation (AE) locations, 10 Expeditionary Medical Support Units (EMEDS), and 2 Contingency Aeromedical Staging Facilities (CASF). We are trained, current and mobile.

Survival rates have improved from 75 percent during Vietnam, DESERT SHIELD and DESERT STORM to 90 percent in OEF/OIF in large part due to forward deployed surgical teams and rapid AE. Total patients evacuated from theater in support of OIF and OEF were 33,615 (October 10, 2001 to April 14, 2006). Of that total, 6,243 were due to battle injuries. Key in the clinical transformation of our AE system is the shift from transporting stable patients to rapidly moving patients requiring continuous in-flight stabilization, putting critical care nurses in high demand. Our highly specialized Critical Care Air Transport Teams (CCATT) moved 711 critically ill patients last year.

The 332nd Expeditionary Medical Group in Balad is currently home to 69 nurses and 97 aerospace medical technicians from the Air Force Total Nursing Force, the Army, and multinational auxiliaries. Nine different surgical specialties are on hand to rapidly provide state-of-the-art treatment including care of massive trauma. These teams have responded to numerous mass casualty surges and have many incredible stories to tell.

One story comes from Senior Airman Timothy Woodall, a reservist from the 349th Medical Squadron at Travis AFB California, serving at Balad. One of his most memorable patients is a three-year-old boy who was part of a tragedy that took his mother's life and left him with 30 percent burns to the right side of his body. SrA Woodall, as one of his primary caregivers, delivered some of his medications, assisted with his routine tube feedings, and had the arduous task of changing his bandages. For SrA Woodall, being at Balad has been an enlightening experience, using more of his clinical skills in two months than he has in the past two years. We are delighted to report that the boy has healed very well and gone home.

Gathering wounded service members and transporting them to higher echelons of care are scheduled missions like the ones flown by a Royal Australian Air Force C–130 aircrew with a U.S. Air Force medical team. "The patients we carry on these missions were injured in some way, down range," reports Captain Kristie Harlow, 379th Expeditionary Aeromedical Evacuation Squadron flight nurse. "Our job is to get them where they need to go for treatment, while providing them the care they need." Litters are stacked, bunk-bed style, in the cargo aircraft. The crew and medics wear body armor and Kevlar helmets for most of the 15-hour mission days, even while tending to patients. All on board agree that the Australian hosts, part of the Australian Defense Force's Joint Task Force 633, provide first class accommodations for the patients and the Airmen who care for them.

Some of our personnel have also risked their own lives to save others. Capt. Kevin Polk received the Bronze Star for saving an injured Airman while deployed as a CCATT nurse with the 379th Expeditionary Aeromedical Evacuation Squadron. He had only been in Iraq a couple of days, when the base came under direct mortar attack. Despite being exposed to enemy fire, Captain Polk searched the living quarters for potential victims, where he found an Airman with life-threatening injuries. He stabilized the Airman's condition and assisted with the medical transport of the Airman to a hospital for emergency surgery. The Airman sustained permanent disabilities, but Captain Polk's heroic response was credited with saving his life.

A typical day at the CASF in Balad consists of recovering two to three aerovac missions from the AOR with patients ranging from routine to critical. In addition, approximately 125 patients are prepared weekly for aerovac missions that transport patients from the CASF to Ramstein Air Base Germany, and then back to the United States. Patient support pallets and additional C–17 litter stanchions have increased the number of planes available for AE. The CASF at the 435th Medical Group, Ramstein Air Base, Germany, continued its high operational tempo, safely

moving 15,093 patients between January 1, 2005 and December 31, 2005 to Landstuhl Regional Medical Center (LRMC) for admission and treatment until they are scheduled to travel stateside. Time and again the heroic efforts of the integrated healthcare team at LRMC come together to save the lives of the wounded Soldiers, Marines, Sailors, Airmen, coalition forces, DOD contractors, and members of the Press Corps. In fact, one Marine said, "I knew that if I got to Landstuhl, I would make it." Countless others share this sentiment.

A talented, multiservice nursing leadership team keeps this smooth running engine moving forward, always poised for the next potential wartime patient surge. Senior Air Force nurses are in leadership roles at LRMC. Col Sherry Cox is the imbedded Air Force Chief Nurse, providing guidance and direction to a team of outstanding nurses in various roles in both inpatient and outpatient roles. Her team found that there is a compelling impact on those who care for wounded Americans, allies, and even the enemy. As a consequence of prolonged exposure to caring for those traumatically injured, healthcare workers are at risk for burnout including feelings of detachment, loss of compassion, significant physiological stress symptoms and reduced morale. LRMC has established a formal program to support the staff and encourage the use of healthy stress coping methods. The major aim of the program is to increase awareness at all levels to the potential risk posed by repeated exposure to combat trauma with early identification and intervention.

The Theater Patient Movement Requirements Center (TPMRC) is the pivotal "behind the scenes" agency facilitating the AE of combat injured troops. As part of the TPMRC team, the Senior Flight Nurse Clinical Coordinator, expedited the transfer of six critically burned service members after an Improvised Explosive Devise (IED) struck their Bradley Fighting Vehicle. Working around-the-clock with the Joint Patient Movement Requirements Center (JPMRC) and multiple European agencies, the TPMRC expeditiously synchronized the transport of these severely wounded troops by a specialized burn team from Brooke Army Medical Center (BAMC), Texas. In less than 48 hours from the time our heroes landed at Ramstein AB Germany, they were receiving definitive treatment at the Military's "Center of Excellence" for burns, BAMC in San Antonio, Texas.

HURRICANES KATRINA AND RITA

The hurricane evacuations of 2005 uniquely challenged our aeromedical evacuation crewmembers (AECMs). AE units and EMEDS from Air Force Total Nursing Force supported the evacuations from Hurricanes Katrina and Rita while MAJCOM-level staff worked around the clock to coordinate and execute the missions. The ANG represented 25 percent of all military medical personnel deployed to the disaster areas with 901 medics for both hurricanes. Despite complex challenges, the teams ensured the safe evacuation of 2,609 Hurricane Katrina patients. On September 3, 2005, the teams moved 580 litters and 300 ambulatory patients, the largest single day of transports since WWII. Over 1,200 patients were moved in 24 hours before Hurricane Rita made landfall. A tremendous amount of orchestration was required between our AE mission coordinators and civilian counterparts to ensure the needs of a massive number of displaced people were met. AECMs worked extraordinarily long hours and loaded patients until they could practically no longer physically carry a litter.

There are many heroes from Hurricane Katrina and the staff of the 81st Medical Group, Keesler AFB is among them. Lt Col Maureen Koch, Flight Commander of the ICU, and her family were among the thousand or so military, family members, and patients who sheltered in the 81 MDG during Hurricane Katrina. Lt Col Koch's focus was on caring for two ICU's ventilator patients and a pregnant woman requiring an emergency caesarean section. Personnel quickly converted one ICU room into a makeshift operating room and the baby was delivered safely. In addition, the medics accomplished many other unprecedented actions. They saved 130,000 medical records, erected a portable bedded facility, accounted for thousands of personnel after the disaster, built new staffing requirements, and re-opened limited primary care services in less than one month after the hurricane.

ANG personnel assisted with the setup of an EMEDS at Charity Hospital in New Orleans and training of the civilian staff. Additionally, medical professionals from the Mississippi, Alabama, Kansas and Delaware Air National Guards erected an EMEDS in Hancock County, MS. Forty-nine percent of the patients treated were from military organizations (AD, Reserve, Guard) and 56 percent were Non-DOD personnel. The ANG provided 68 percent of all immunizations given in the surrounding area.

Hurricane Rita operations, staged out of Beaumont, Texas were confronted with preparing and transporting a large number of elderly patients with a Category five

storm scheduled to make land-fall in less than 24 hours. Chief Master Sergeant Rodney Christa, a reservist, from the 433 AES, Lackland AFB TX, was appointed to the on-scene Command Element for both hurricane evacuations. Chief Christa stated, "Although the number of patients we had to transport was greater for Hurricane Katrina, Hurricane Rita was more stressful because the storm was bearing down upon us. Time was critical. Hospitals, nursing homes and private citizens were literally driving up by the busload to our doorstep. We had no idea what to expect; we received patients on ventilators, those needing dialysis and newborns. All needed medical care. At one point, I thought we were going to have to leave medics behind to remain with patients and ride out the hurricane. The patients were arriving faster than we could airlift them to safety. With teamwork, we were able to get everyone on the last aircraft available before the winds were too strong to allow us to take-off."

On September 22, 2005, an ANG crew from the 167th AES led by flight nurse, Major Jay Sandy, from Andrews AFB, MD, launched a C–5 Galaxy to Beaumont, Texas, to evacuate 117 incapacitated nursing home and hospitalized patients. During the flight to Dobbins AFB, they experienced several medical emergencies that were rapidly stabilized in-flight due to the highly experienced medical team. The Georgia Civil Defense Team of 100 volunteer physicians, nurses, and other personnel assisted with the offload and management of the evacuees. This mission was successful due to the superior leadership, professionalism, teamwork, and medical expertise of all involved.

CLINICAL SUCCESSES

Air Force Nursing Services is globally engaged, at stateside and overseas locations, in the enhancement of patient care outcomes through outstanding initiatives. In fiscal year 2005, we supported 1.2 million TRICARE Prime enrollees and over 66,000 TRICARE Plus enrollees throughout the world. Currently, we have 19 Air Force hospitals and medical centers and 56 clinics. We would like to share some of our home station clinical successes.

As you well know, the Family Advocacy Program's purpose is to prevent and treat family maltreatment. Mrs. Mary Fran Williamson, a civilian Family Advocacy Nurse at Offutt AFB, led the development of nursing practice guidelines to use for the care of family maltreatment cases and in the prevention of abuse. These guidelines recommend appropriate nursing interventions and were incorporated into the Air Force Parent Support Program, accessible via the internet-based Family Advocacy website.

Our partners in the Reserves spearheaded the first-ever DOD-wide video teleconference on Sexual Assault Answer. Lt Col Susan Hanshaw, a Reserve nurse assigned to the Armed Forces Institute of Pathology (AFIP), serves as the consultant to the Assistant Secretary of Defense for Health Affairs. In this role, she co-authored the DOD policy for sexual assault and directed the AFIP-sponsored Sexual Assault Response Team (SART) Training Program.

In one of our overseas locations, at Kaiserslautern Military Community (KMC), Germany, they are overhauling their primary care services. A unique feature of this endeavor is the establishment of a Women's Health Center, spearheaded by a Women's Health Nurse Practitioner, Major Elizabeth Decker. The goal of the Center is to improve access to care for women throughout the KMC, including active duty, dependents, DOD's teachers and civilian contractors. One highlight will be a specially designed "Comfort Room", specifically to support sexually assaulted victims. It will provide a soothing environment away from the emergency room for privacy and counseling.

On another continent, Independent Duty Medical Technicians (IDMTs), TSgt Steven Yates and TSgt John Strothenke from Eielson AFB, Alaska deployed in support of the Joint POW/MIA Account Command (JPAC) mission, which recovered the remains of 19 service members in the last calendar year. In addition, IDMTs supported forward-stationed detachments in Laos, Vietnam, Thailand and Cambodia by providing influenza vaccines, conducting Self Aid and Buddy Care classes, and giving Avian Flu awareness briefings. JPAC IDMTs assisted active duty physicians in Laos and Cambodia in conducting Medical Civic Action Programs (MEDCAP) for local villagers assessing and treating a wide variety of jungle ailments.

As the Department of Defense expanded its global reach, it became evident that understanding other cultures and languages is paramount. For several years, the Air Force Nurse Corps supported the development of cultural awareness and linguistic expertise through various humanitarian relief and military operations. Through the International Health Specialist (IHS) Program we gained access to countries that are otherwise somewhat inaccessible. Major Stephanie Buffet, an IHS

nurse, currently working for the CENTCOM Surgeon General, played a pivotal role in the Air Force's response to medical issues in the ongoing Pakistan earthquake relief efforts. She advised the Task Force commanders on building healthcare capacity with the Pakistan medical system and served as a liaison with the civilian and host nation response agencies.

A1C Stella Bernard, a medical technician in the Pediatric Clinic, from the 9th Medical Operations Squadron, Beale AFB CA, was a member of a 13-person medical team sent to Asuncion, Paraguay. She served as a Spanish interpreter as well as a medic. During their 10-day mission over 7,800 Paraguayans were treated with medical, dental, and preventive health services. A1C Bernard described this experience as "priceless".

Lt Col Diep Duong, a graduate of an AF-sponsored doctorate degree, directly supported multiple international medical missions. She established personal and professional relationships with senior medical leaders and U.S. defense attaches in Vietnam, Cambodia, and Laos. She led a 5-member multi-service medical team to Phnom Penh, Cambodia. Team members screened and treated 1,205 patients, delivered six babies, completed 263 prenatal visits, filled 2,378 prescriptions and distributed over 2,000 bed nets. An important component of this mission was collaboration between the United States, Cambodian and Cham Muslim health care providers to ensure appropriate and culturally sensitive delivery of health services to local women and children.

Air Force Nursing Services made an impact at the national-level as well. In May 2005, the American Association of Critical Care Nurses (AACN) recognized the CCATT nurses at the 59th Medical Wing for Excellence in Clinical Practice, Non-Traditional Setting. This award reflects the contributions of the entire team from the field medic to the tertiary care centers. In March 2006, the American Academy of Ambulatory Care Nurses presented national level awards to two AF nurses at their annual conference. Major Christine Taylor, from Dyess AFB won the Outstanding Nurse/Clinical Excellence Award and Lt Col Carol Andrews, from Randolph AFB won the Outstanding Nurse/Administrative Excellence Award. The Air Force Affiliate of the National Nursing Staff Development Organization (NNSDO) was awarded the prestigious NNSDO 2005 Affiliate Excellence in Quality Program and competed as a finalist for the Chief of Staff Team Excellence Award.

Our influence is also evident at the state level. A clinical nurse, Captain James Gabriel, received the Governor's Alaska Council on Emergency Medical Service (EMS) Award/Melissa Ann Peters Memorial Award. He orchestrated a benchmark Emergency Medical Technician (EMT) training program, which is now a model for the Interior Alaska Region Emergency Medical Council. Lt Col Roseanne Warner, a Family Nurse Practitioner from Cannon AFB, was the recipient of the American Academy of Nurse Practitioners New Mexico State Award for Excellence.

RECRUITING AND RETENTION

As you can see, Air Force Nursing Services is globally engaged, making recruiting and retaining nurses one of our top priorities especially with the national nursing shortage. On the civilian-nursing front, the Bureau of Labor Statistics reports that jobs for registered nurses will grow 23 percent by 2008. Nurses are entering the workforce at an older age with new graduates averaging 31 years old.

SKILL SUSTAINMENT

Col Florence Valley, Chief Nurse at the 332nd Expeditionary Medical Group, Balad AB, Iraq, stated, "when the Air Force Nurse Corps goes to war it brings inpatient nursing and aeromedical evacuation skills. These are our primary contributions to the war fighter." Great strides have been made to ease the transition from home station to warfront nursing care. For example, Wilford Hall Medical Center (WHMC) and the Air Force Theater Hospital (AFTH) in Balad have similar nursing requirements, which minimizes spin-up time. We credit this to the nurses' current inpatient care experience and to the continuous improvement of pre-deployment training.

I agree that the best way for nurses to maintain currency and to be effective in deployed settings is to have recent hands-on experience as inpatient clinical nurses. Maintaining our basic technical skills while working in areas where the skills are not used regularly, led to an updated policy on nurse utilization. Recently, I released a policy mandating that nurses working in outpatient and non-clinical roles will be required to complete a minimum of 168 hours annually on the inpatient units annually to maintain their skills. We believe that bringing seasoned clinicians back to the bedside will not only provide a more robust technically-ready force, but will also provide a setting of mentorship for our less experienced nurses.

Our senior leaders are already engaged, emphasizing clinical operational currency and expertise. Numerous VA Training Affiliation Agreements (TAAs) allow nurses to rotate to inpatient wards, maintaining their clinical skills. According to Lt Col Martha Johnston, Chief Nurse at the 377 MDG at Kirtland AFB, "The nurses love it!" The 377 MDG plans to expand the program to include the aerospace medical technicians.

Due to the unique missions at Balad, WHMC added the Defense Medical Readiness Training Institute's (DMRTI) Emergency War Surgery Course to their pre-deployment training to familiarize nurses with Balad-specific surgical procedures and care. Additionally, the nursing staff attends the Emergency Nurse's Association's Trauma Nurse Core Course (TNCC), which standardizes the approach to patient assessments. Finally, WHMC nurses attend a burn management course at BAMC.

The criticality of patients seen in deployed areas significantly changed our definition of skills sustainment training requirements. To meet the needs of our deploying nurses, we are increasingly using the Center for Sustainment of Trauma and Readiness Skills (C–STARS) training platform. The goal of C–STARS is to produce medics ready to respond to any peacetime or wartime contingency through intense clinical immersion. Training is augmented by participation in trauma scenarios based on actual wartime medical missions using high-tech human patient simulators programmed to respond realistically to medical care. Not surprisingly, nurses who attend advanced training platforms such as C–STARS report an easier transition to the deployed environment. One of our deployed nurse anesthetists, Major Brent Mitchell believed that without C–STARS training, he wouldn't have been nearly as effective.

The Uniformed Services University of the Health Sciences (USUHS) Graduate School of Nursing (GSN) Master Programs developed academic initiatives for the enhancement of "Go-to-War" Skill Sets of Advanced Practice Nurse. Some of these courses include Advanced Trauma Care for Nurses (ATCN), preparing students to function in operational environments and a Registered Nurse Surgical First Assistant, optimizing surgical outcomes.

The GSN Masters Program 2005 fall enrollment was at an all time high of 140 students. Over the past twelve years, Air Force nurses comprised 41 percent of the overall enrollment and specifically contributed to 43 percent of the Peri-Operative Clinical Nurse Specialist track. Since 1996, 62 percent of the CRNAs were Air Force graduates and we are proud that our Nurse Anesthetists once again had a 100 percent pass rate on the National Certification Exam. The three Air Force Doctoral Studies students are currently preparing for qualifying exams and grant proposals. Colonel Lela Holden, a part time doctoral student, is also moving into the dissertation phase of her program.

RESEARCH

Air Force nurses continue to remain at the forefront of operational research. Their work expands the state of nursing science for military clinical practice and infuses research into evidence-based practice. Lt Col Laurie McMullan, a nurse anesthetist forward deployed with the 447 EMEDS, employed the findings of a Navy research article on the "Effect of Needle Size on Success of Transarterial Block". She performed this short-needle regional anesthetic block on five Army soldiers requiring upper extremity surgical procedures, offering alternative anesthesia with a successful post-operative pain relief. We thank the Navy for their research, which allowed this Air Force nurse anesthetist to provide outstanding combat anesthesia to Army soldiers.

Other crucial areas of research being examined by Air Force nurses include Deployment Health, Sustaining Competencies, Military Practice Outcomes and Recruitment & Retention. Lieutenant Colonel Theresa Dremsa, a nurse at WHMC, is one of the Air Force's leading operational researchers and her current focus is to measure CCATT nurses' preparation for deployment. Her study examines the experiential knowledge of CCATT nurses in the care of critically ill or injured patients in a high-risk deployed setting. The results will be used to guide clinical practice in the future.

As large numbers of deployed members return home we must remain adequately prepared to help these veterans and their families with reintegration. Though return from deployment can be a happy occasion, homecoming can turn into a stressful event for troops and their families who are not alert to the impact of changes that occurred during separation. Unidentified and untreated PTSD puts them at higher danger for maladaptive responses to stress such as alcoholism and domestic violence. Colonel Deborah Messecar, from the Portland ANG, is conducting a study

to explore the experiences of ANG military families with reintegration and identify resources and strategies to assist them.

Disasters around the world over the past year have also emphasized the need to find ways to help affected military families. Research by Colonel John Murray, Consultant to the Air Force Surgeon General for Nursing Research, helped explain the consequences of disasters on children and provided the field with a framework to guide further research and clinical practice.

OUR WAY AHEAD

Several major events continue to shape our future. The Air Force transitioned to an expeditionary mission and now deliberately prepares our Airmen through aggressive Force Development policies and programs. In his 2004 letter "Developing Expeditionary Medics—A Flight Path," former CSAF, Gen John Jumper tasked the AF SG to "complete a comprehensive review of the medical group structure for our garrisoned and expeditionary medical groups." We have since developed a new Flight Path to guide our organizational structure and the development of our clinical discipline. The Flight Path guides more deliberate development for Nursing Services, placing the member in the right job at the right time, setting them up for career success and personal satisfaction while maintaining expertise at the frontlines of patient care.

The results of the BRAC mark a dramatic shift in DOD and Air Force healthcare capitalizing on multi-service markets, joint and interagency facility use, and civilian healthcare agreements. Air Force Nursing Services is already preparing for the many BRAC-related challenges by finding alternate inpatient platforms to train and sustain nursing personnel and by determining the right composition of active duty "blue suit" nursing requirements. We continue to evaluate our bottom-line deployment-driven Critical Operational Readiness Requirements (CORR) and use market availability along with cost data to recommend appropriate civilian conversions. The Nurse Corps plans to target company grade outpatient and maternal-child care positions for potential conversion while maintaining active duty nurses for inpatient platforms and other key career development positions.

Along these lines, the results of the 2001 Air Force Surgeon General-directed Nurse Corps Top Down Grade Review (TDGR) continue to guide our actions as we strive to balance our company grade and field grade authorizations. We remain optimistic that our course of action will help improve overall promotion opportunity therefore increasing the retention of our experienced nurses. We've successfully increased field grade requirements for deploying nurses and are taking steps to lay-in more senior clinicians at home station.

Mister Chairman and distinguished members of the Committee, it is an honor and a privilege to lead the men and women of our active, reserve and guard Nursing Services. My objective for this presentation was to provide you with a glimpse of the extraordinary men and women that make up Nursing Services and the exceptional work they are doing daily in the service of their country. I look to the future optimistically and desire your continued support during the exciting times ahead for nursing and our Air Force. Thank you for inviting me to tell our story.

Senator STEVENS. I thank you very much for your statements. I'm a little bit hesitant to ask questions, in view that I'm sitting here with the father and mother of the nursing corps of the Department of Defense. So they really have put in a lot of time, and, I must admit, a great deal more than I have. I do want to ask a couple of questions, though. I'm told the Army is short about 320 nurses. And you've heard, I believe, the conversation we had with the prior panel about the possibility that we might consider unification. Would unification help your corps at all? Would you tell me, General, and then Admiral and General?

General POLLOCK. Yes, I think that a joint unified command would help us. It provides more opportunities for the nurse corps officers because of the different platforms that we do have across the services. And it will also, I believe, be a retention tool, because there are times during our career that there are issues with our other families, our nonmilitary families, our families of origin, our siblings, where we feel a need to be closer to those families. By ex-

panding the assignment locations, we would be able to offer them more variety across the Nation for locations, and then also retain them.

Senator STEVENS. I know some women that I've talked to in the past don't like to fly. Others would not want to serve on a ship. Would unification give you problems with regard to the platforms that they might have to work on?

General POLLOCK. If I were in charge of planning it? No, sir. Because I think that we've chosen a particular uniform. And that would be our first emotional obligation, was to the organization that we had started with. But by giving people some flexibility, our younger staff are often very curious, and they're looking for new experiences in new locations. And having that as an option, not a mandate, would help us.

Senator STEVENS. Admiral.

Admiral BRUZEK-KOHLER. Thank you, sir. Yes, I think nurses, historically, have been able to informally make sure that the kinds of training and the kinds of experiences they need across the services and with our other agencies—in particular, with the VA and the public health—have always helped us to sustain, maintain, and grow. Having a unified medical command brings down the walls that help us to do that in a more effective and efficient way. I often say that the best retention tool I could have would be offering orders to Tripler to my Navy nurses.

I'm the first one in line to get a set of those orders.

So, absolutely, I think the possibilities for us, as corps chiefs and for all of our nurses, would be greatly enhanced by a unified medical command.

Senator STEVENS. General Rank.

General RANK. Sir, I mentioned in my testimony that there are already opportunities where we are side by side together. We are at Landstuhl with the Army. They are in Balad with us. And we have continued to offer, where they are short; and they have offered to us, where we are short, to work side by side in our inpatient platforms where we are critically manned.

We are on an Air Expeditionary Force (AEF) cycle of 120 days, where we go to the U.S. Central Command Area of Responsibility. I, like my sister from the Navy, would love to be able to keep our unit type code (UTC) together, but find platforms in the Army and the Navy that keep us current. I would love to lay nurses into places like Balboa and into Tripler. We are working, already, on that endeavor, with Walter Reed. And, as I mentioned before, we already have laid in staff for Landstuhl, with an Air Force chief nurse working side by side with the Army.

We are doctrinally different, and we train for care in the air, and we train for contingency air medical staging flight support. The Navy and the Army also are doctrinally different. But I think that we can work through all of our clinical platforms side by side, green, black, and blue together, and know what our heritage was, and work together with our heritage still blue, black, and green.

Senator STEVENS. I hesitate to ask this—I'm the father of three sons and three daughters, so I would ask it advisedly—has there been any reluctance on the part of nurses to be deployed into the war zone?

General.

General POLLOCK. I think there's reluctance always to have new experience. And certainly that is one that they know is very intense. I think that they're more concerned about the length of time that they're deployed, sir, because what they do is different than what the infantry and the armor and the other military members do, because each day that the nurses and medics and physicians are serving in those combat hospitals, every day they're dealing with an injured soldier or marine or airman or sailor. They don't have any relief from that. And as they express it to me, "Ma'am, we're willing to go. We know they need our help, and we want to be there. But a year is just wearing us down." So, I don't think that it's their—that they're afraid to go, because once they're there, they understand how valued they are by that community and how their loving and touching hands make a huge difference, but the duration of time that we're asking them to go now is really very, very hard on them.

Senator STEVENS. Have there been more deployments from any one of the services, as opposed to the other, into the war zone? Which of your services have sent more nurses into the war zone?

General POLLOCK. Sir, I would say that the Army has—we—we're the primary ground force. It's been a ground operation. We have had some support from both the Air Force and the Navy, but the majority of work is being done by the Army nurses.

Senator STEVENS. Here again, unification might give you a larger reservoir of people to rotate, correct?

General POLLOCK. I would be very grateful if we were able to balance the rotations among all of the specialists that are required, so that people did not need to deploy a second time, until they knew that their colleagues that had the same competency and same skills had also deployed.

Senator STEVENS. Admiral——

General POLLOCK. That would be a huge morale booster.

Senator STEVENS. Pardon me. Admiral, what's your feeling?

Admiral BRUZEK-KOHLER. Well, I'd like to agree that the Army has given us the largest volume of nurses in the battlefield. Navy nurses have—however, if you recall, are with the marines, as well as with our fleet, so our—although not always in war, they are with our sailors and marines throughout the year in many short-term deployments, as well. I'd like to illustrate it simply with a phone call that I made about 2 weeks ago. I was told that one of our Navy nurses is in Iraq and was injured by some shrapnel, not seriously, thank the Lord. When I talked to her, via telephone in Iraq, she was able to convey to me how important it was that she be where she was. She's the mother of five children, and a husband who's Active duty, as well. She had been offered, immediately after her treatment, and was offered by myself, to come home, and she said, without quivering, "Absolutely not."

I will tell you that everywhere I go, our Navy nurses want desperately to serve with our marines and with our sailors. That's why we put the uniform on, that's why we are here. Do we like being away from our families for a year? Absolutely not. Do we understand why that is an important thing that we do? Absolutely.

Senator STEVENS. General.

General RANK. As our personnel get ready to deploy, there is trepidation. It's trepidation about leaving the known, trepidation about what—how safe they'll be while they're there, trepidation about leaving their family behind. But there hasn't been a single nurse or medical technician that hasn't returned and provided an account to me in our Nightingale News every week when we put out our updates to what's happening in the nursing services that when we ask anyone, "What was the highlight of your career?" they tell us, "It was when we deployed. It was when we were far forward. It was taking care of the injured." So, they do return rejuvenated and—with what they've just done, and it is their most memorable experience.

In 2003, 407 of our nurses deployed; in 2004, 261; and in 2005, it was 394. Our inventory is 3,675. Only 11 percent of our nurses have been able to go to the U.S. Central Command Area of Responsibility. Granted, some of these skills are high-demand, low-density, but there is not a nurse, as I move through the Medical Treatment Facility (MTF), that doesn't say to me, "I want to deploy, and I'm ready to deploy." And we have laid in, in our UTCs, as I mentioned in the testimony, more seniority, so that it's not just our captains going, over and over again; now our majors can go, and now our lieutenant colonels can go.

And I would say of our relationship together, give us a mission, give us one of your missions, like we are doing in Balad, and we will do that mission, and stand proud to do that total mission.

Senator STEVENS. Well, thank you all very much. I have another appointment. I'm going to ask the co-chairman if he will continue this hearing.

Thank you very much.

Senator INOUYE [presiding]. Thank you very much.

All of the services have not been able to meet their recruiting goals. And I think that's understandable, because the nursing shortage is a national problem. I just read the report of the American Association of Colleges and Nursing that reported last year there was an increase in enrollment for entry-level baccalaureate programs in nursing, by 14 percent; however, at the same time, they turned away 32,000 qualified applicants. With that, we won't be able to solve the problem. Do you have any suggestions as to anything we, in the Congress, can do to work on this national shortage?

General Pollock.

Admiral BRUZEK-KOHLER. I think that one of the most important things that we all need to recognize is the importance of the role of the nurse. We need to market the expertise, the care at the bedside, the care of family that is unique to the profession of nursing. You do not see that in other types of care. I think they need to be incentivized to be able to make that a profession, as well as a part of a lifestyle for those wanting to raise a family or to get an education and further their careers.

This year, in the Navy, we have instituted as many of the opportunities afforded to us with our loan repayment programs, but, most importantly, we have pipeline programs within the Navy, so that we give an opportunity to our enlisted staff to become nurses, and we are depending more and more on that population for the

health and the breadth of the Navy Nurse Corps. I believe that our direct accessions in the future need to be more pointed toward those with specialties, as opposed to our new graduates. Again, when you look at the wartime skill sets, we don't train enough critical care nurses, we don't train enough perioperative nurses. I need to bring them in, I need to get them hitting the deck, and I need to get them providing that kind of care as quickly as possible. So, we need to be able to incentivize bringing in nurses with more seniority in the civilian practice, rather than those who are looking at this as a future, as a new graduate.

Senator INOUYE. General Pollock.

General POLLOCK. Thank you, sir.

I think that the profession of nursing continues to struggle, because they've not completed a transition that was started in the early 1970s. Other professions are recognized for their college entry into that profession. And until nursing across the Nation completes that transition, which it started then, we will continue to not be well recognized as professionals. And with the opportunity that men and women have now, they're selecting professions that will provide a better lifestyle and a better income for their families. So, dealing with the lack of respect that nurses have in the Nation is an integral step to solving the nursing shortage.

Another piece is the low salary and high demands that are placed on the faculty members at the universities, because when people have an option of being a faculty member or working in another facility as a nursing executive, because they're master's or Ph.D. prepared, very few are opting to take that lower salary, that lower respect afford in the academic community. They're selecting where they can lead and mentor nurses in other areas.

Those issues must be addressed nationwide in order for us to be successful in the future as nurses.

Senator INOUYE. General Rank.

General RANK. General Pollock and Admiral Bruzek-Kohler just said everything I was about to say. I would ask, Senator, if there is any way for us to establish more publicity for healthcare careers at the health affairs and congressional levels. That would certainly help, beyond a recruiting effort, to bring some of the nurses to us. But I ditto what my colleagues have said about the nursing shortage, in that it's pervasive and carries over into our services.

General POLLOCK. Sir, I'd like to make one more comment about that and the need that we will have for those educated nurses with entry at a baccalaureate and proceeding on for a master's and Ph.D. work. The research over the last 5 years strongly indicates that patient safety and patient outcomes are far better the higher the education level of that nurse that's caring for them. So, as we look at the needs and the complexity of the patients that are presenting now, it becomes even more critical that we address the failure of the universities to be able to bring in the faculty that they need so that we can care for the citizens of our country.

Senator INOUYE. I've always contended that pay plays an important role in recruiting. It's a fact of life. And there's another factor, in this case, where the nursing profession appears to be female-dominated. And this is a man's world, unfortunately. And the male gets a better pay scale than the woman. Now, in the civilian nurs-

ing community, there are not too many men working as nurses. What is the proportion, in the Army, of men?

General POLLOCK. Sir, the Army Nurse Corps is 32 percent male, compared to less than 5 percent in the civilian community.

Senator INOUYE. And for the Navy?

Admiral BRUZEK-KOHLER. Thirty-seven percent, sir.

General RANK. Twenty-five percent male, sir.

Senator INOUYE. What can we do to encourage more male participants in the nursing programs? Because then the pay scale will go up?

Those are the facts.

General POLLOCK. I think that some of the public-service announcements that have been done by Johnson&Johnson in their nursing advertisements across the Nation have been focusing on males. It's been relatively easy inside our organizations, because our enlisted soldiers, again, are primarily male. They see what military nurses do, and they make that commitment to then complete their education and be a member of one of our corps. So, getting more of the men out, which all of us are doing through our recruiting efforts, helps to let the other men in the communities know that may have been concerned, "Gee, I'll only be such a small portion of the percentage of nurses," that there really are organizations in which they have a large place.

Senator INOUYE. Thank you.

Senator Mikulski.

Senator MIKULSKI. Thank you, Mr. Chairman—or Mr. Acting Chairman. I don't know if that's a battlefield promotion you just got here today.

You can see, from Senator Inouye's questions, why we just so admire him and the chair who's serving with him.

Senator Inouye, you should know that not only is Maryland the home of medical medicine, but two of our generals graduated from the University of Maryland School of Nursing. And——

Senator INOUYE. Oh, really?

Senator MIKULSKI. General Kohler, I guess we have to give you an honorary something-or-other.

And General Rank actually was born in Frostburg, Maryland, Garrett County, the Switzerland of Maryland. So, there is something——

General RANK. Allegheny.

Senator MIKULSKI [continuing]. Excuse me—Allegheny—there is something that's a magnet here.

I'd like to pick up on the nurse education issue that Senator Inouye raised. And the point that he made, all of the issues about attracting people to the career of nursing are right—respect, pay, et cetera. But I have a little advisory board of the nine deans of nursing of the 4-year programs in Maryland, the dean of the University of Maryland and Johns Hopkins, and then other 4-year programs. And what they, of course, tell me is, they are now turning away—the issue of not being interested is no longer so—they're now turning away people who want to come to nursing. They identify the lack of graduate faculty and the lack of clinical training opportunities, the hands-on that, of course, is the hallmark of the field.

And I think this is a national crisis. We have the civilian crisis, which would transfer to your ability, because you're in a war for talent, in addition to the global war on terrorism, so you're going to the same pool, so it's magnified for all of the stresses that you've just said. So, my question is: What is the role of the military? Because when we want to do an intense program, we tend to do it. What is it we could do? Do you think we could be looking at focusing on training, getting ready for some special accelerated or expanded program to get people to go to graduate school, with the understanding that they would go into nursing education? Should we use USUHS? Should that be the military academy for nursing educators to then train nurses? Should we expand the USUHS model? Should—you know, we graduate about 1,000 midshipmen; how do we graduate 300 to 500 nurses a year? And is USUHS one of the ways of doing this? And also to take out of, as you said, the pipeline, some of your really talented people who want to make not only military a career, but as they transit, say, from battlefield or TRICARE, they would love to be nursing educators. What's your thoughts on that? Is USUHS something, or are there other linkages that the military could have with our civilian sector for nursing education? And should our military bases and military medicine be the source of clinical opportunities for people? So—you tend to go with what you know—so, if your clinical is at Maryland or Mercy Hospital, you tend to stay there, almost like the so-called 3-year girls. You remember that. And—but if they were in the military, that would also be part of your attraction, the way General Taylor and others talked about recruiting. What do you think? Or am I off the wall here?

General POLLOCK. In the past, ma'am, the Army Nurse Corps had run a full baccalaureate program. That program was closed in 1978. That was the Walter Reed Army Institute of Nursing Program. At current strengths, I would not be able to manage that mission and do the other missions that we have, both at home and around the world.

Until we're able to figure out where we can draw the faculty from, even if USUHS was willing——

Senator MIKULSKI. What I'm asking you——

General POLLOCK [continuing]. We wouldn't be able——

Senator MIKULSKI [continuing]. Where could we play a role in developing the faculty to then expand it, where we keep—unless we crack the faculty problem, both in the civilian and in the military sector—and I'm looking at cracking it from the military standpoint, that the military would have its own faculty cadre——

General POLLOCK. Ma'am, I've had a Strategic Issues Working Group working on the education piece for me. What I'd like to do is provide you a written response of——

Senator MIKULSKI. Good, why don't we do that.

General POLLOCK [continuing]. Recommendation——

[The information follows:]

Each year, thousands are denied entry into baccalaureate nursing programs due to faculty shortages. The fiscal year 2005 National Defense Authorization Act recommended the creation of a Nurse Officers to Educators Program to address this issue. A complicating factor related to this issue is a concomitant national shortage of nursing faculty. A 2005 American Association of Colleges of Nursing survey reported 817 faculty vacancies nationwide, with 77 percent of those positions requiring

both classroom and clinical teaching. The study also reported that many schools are not hiring against these vacancies due to budget problems. The Army recommends that the three military Nurse Corps serve as members of a working group to identify solutions to this national crisis.

Senator MIKULSKI. Do the other Generals have a comment on this? And I'm trying to think out of the box, but I don't want to get myself into a new box——

Admiral BRUZEK-KOHLER. Yes, ma'am.

Senator MIKULSKI [continuing]. You know.

Admiral BRUZEK-KOHLER. I think there are—there are many innovative ways to approach exactly what you're asking for. And I agree with General Pollock that we need an opportunity to sit together and provide you some background on the pros and cons to many of those. But you did mention the clinical rotations, and that is one of the major factors. I've spoken with the dean of Marymount not too long ago, and that was one of her biggest concerns, that she was not able to get enough faculty—clinical faculty working in an institution to train her graduate students. So, I think one of the things that we need to work more on, along with our sister service and the VA, is to determine ways that we can better link up our clinical institutions with the surrounding schools of nursing to make sure that we're giving them enough opportunity. Because sometimes it's just a matter of not knowing the need. We have nurse practitioners in most of our ambulatory care clinics. I know for a fact that my nurse practitioners would love to be a mentor to a graduate student who was going on to become a nurse practitioner.

So, I think if we have the opportunity to provide you with some more information, we may come up with some good activities for you.

[The information follows:]

On an annual basis, the Navy Nurse Corps shapes our graduate education training plan based on our health care and operational mission support requirements. Approximately 50 Nurse Corps officers graduate with a Master of Science degree in Nursing from accredited universities each year. On average, one to two Nurse Corps Officers graduates each year with Doctoral Degrees. These Nurse Corps Officers are eligible to serve as faculty in our universities and Schools of Nursing while on Active Duty, and upon retirement. Eighty-eight percent of our Active Duty Nurse Corps Officers with Doctoral degrees serve as faculty after normal working hours. Currently 100 percent of our most recently retired Nurse Corps Officers with Doctoral degrees fill faculty positions in national universities. The majority of Nurse Corps officers with a Master of Science degree in Nursing do not pursue faculty roles in Nursing Education for a variety of reasons. These reasons are in alignment with current literature related to nursing faculty shortages. Navy Medicine currently has a Nurse Corps Leader who serves as the military liaison to the Maryland Statewide Commission on the Crisis in Nursing.

Other opportunities to promote and encourage our nurses to become involved in faculty roles are available in our Military Treatment Facilities (MTF). The Nursing Internship Programs utilize our Bachelor's and Master's degree Nurse Corps Officers as clinical instructors to orient recent graduates and Registered Nurses with minimal clinical experience to the profession of nursing. A large percentage of our MTFs and staff are involved with undergraduate and graduate Schools of Nursing as preceptors and clinical consultants to grow the next generation of nurses.

Many of our Nurse Corps Officers are members and elected officials of Sigma Theta Tau International Honor Society of Nursing in affiliation with their local chapters in support of leadership and scholarship practice. Members are provided resources which encourage advanced practice, academia, administration and research.

At the Uniformed Services University of Health Sciences (USU) in Bethesda, Maryland, several of our Navy Nurse Corps Officers serve as faculty in the graduate

programs for perioperative nursing, family nurse practitioner and certified registered nurse anesthetists. USU is experiencing faculty shortages in light of meeting our primary mission involving the Global War on Terrorism. Presently, the civilian schools of nursing meet our quotas for undergraduate accessions and graduate and post graduate programs. Navy Medicine recommends expanding the Army's Strategic Issues Working Group into a Tri-Service working group as a subcommittee of the Federal Nursing Services Council. It's mission would include opportunities for the services to collaborate with civilian schools of nursing to positively impact the issue of the national nursing faculty shortage.

The issues involving the national nursing faculty shortage are very complex and multi-layered such as aging faculty, faculty salaries and mentoring programs for new faculty. The Navy Nurse Corps is committed to continuing to explore opportunities that would maximize the use of existing resources along with our sister Services and Federal agencies to map the future for the nursing profession.

Senator MIKULSKI. And one of the things that sometimes happens in a clinical situation is, the person who is the clinical supervisor, in addition, say, you know, at Mercy Hospital with Marymount, or Mercy Hospital with Maryland, they can have an adjunct faculty status.

Admiral BRUZEK-KOHLER. Yes.

Senator MIKULSKI. They like that.

Admiral BRUZEK-KOHLER. Absolutely.

Senator MIKULSKI. They just like it. It's part of the attraction, as you said, and it's part of that family, "Well, you know, we're military nurses," and, "Mom does this," and, "Mom's on the faculty," or, "Dad's on the faculty."

The other is the promotion within—not the promotion, but the recruitment within, the corpsman who might want to go to nursing school. Like Senator Inouye said, the guys getting into nursing. Are there ways that we could enhance it? In other words, they've signed up for the military. They've signed up for the military lifestyle, and so has their family. So, there's nothing new here. But the opportunity to move within, is this something that we should look at, enhance, expand, help you have other tools——

Admiral BRUZEK-KOHLER. Yes, to——

Senator MIKULSKI [continuing]. Financial resources?

Admiral BRUZEK-KOHLER [continuing]. All the above. Yes, to all the above. It is the lifeblood of our nursing services for the Navy. We have the Reserve Officer Training Corps (ROTC)—Navy ROTC program, the STA–21, which is seaman to admiral program, the Medical Enlisted Commissioning Program (MECP) enlisted program. And without those programs, we would never meet our accession goals. They really give us the strength and breadth of our nurses for the future. And these are people who are committed to the Navy. They are not always our corpsmen, they are, across the board, our best and brightest, who want to become a nurse, and go through these programs, and then commit to a long term in the corps. So, we are looking at increasing, in all of those programs, the number of available seats for next year. We hope that we can continue to increase those numbers.

Senator MIKULSKI. You mean, somebody right now who might be working as a medical librarian or in another area in the military wants to come into nursing.

Admiral BRUZEK-KOHLER. Someone maybe on a ship right as a cyto——

Senator MIKULSKI. Cytologist?

Admiral BRUZEK-KOHLER [continuing]. A cryptotech—a cryptotech, nonmedically related at all, but had a desire all along to be a Navy nurse, applies to the program, meets the requirements, and is selected, and will become a Navy nurse.

Senator MIKULSKI. General Rank, did you want to say anything?

General RANK. Ma'am, in preparing for testimony, I found an interesting fact about our enlisted corps: 24 percent of our nurses in the Air Force were prior enlisted; 8 percent came from the Air Force and 16 percent from the Army and the Navy.

Senator MIKULSKI. See? They're there. They're there in the military, and they've embraced it. You know, there is a saying, "Mine where there is gold," "Drill where there is oil, as long as it's not off the coast of Ocean City."

And——

General POLLOCK. Ma'am?

Senator MIKULSKI. I just think that this offers opportunities, but they still have to go somewhere to school. And see what we can do about that. I'd like to have further conversations or written materials on it.

The last thing is, has the debt repayment programs made a difference? The reason I like debt repayment is, it means you've already got yourself through school—you know, you start nursing, it might not be for you. So, it means you've not only finished it, but you've passed the boards, you know, you're ready to go. Has this worked?

General POLLOCK. Yes, ma'am.

Admiral BRUZEK-KOHLER. Yes.

Senator MIKULSKI. Do you like it better than scholarships, or you need a mix?

General POLLOCK. I'd like both. We have a population that likes options and wants alternatives. So, knowing that we can offer some—it's almost a cafeteria plan, some of this and some of this—is really helpful.

Ma'am, I'd like to provide one other piece of information about our enlisted commissioning program. This year, we funded 75 soldiers to complete their baccalaureate degree. So, in 2 years, they'll be available for us. We had 125 applicants, and 122 of them met all criteria. So, as——

Senator MIKULSKI. And why did you only do 75? Is that all the money you had?

General POLLOCK. Yes, sir—yes, ma'am.

Senator MIKULSKI. Well, Senator Inouye, this might be where our biggest pool is for recruitment. And we should look at what the levels are there and welcome thoughts about how maybe——

General POLLOCK. General Kiley——

Senator MIKULSKI [continuing]. This is——

General POLLOCK [continuing]. Has been assisting us——

Senator MIKULSKI [continuing]. An existing pipeline.

General POLLOCK [continuing]. In that——

Senator MIKULSKI. Excuse me?

General POLLOCK. Sorry. General Kiley has been assisting us to obtain more money for that, because he knew that we had those additional candidates ready to go.

Senator MIKULSKI. But I bet we could go to each service, and that would be the case. Am I right, that you have now more than you can fund? But if we fund them, it's a pretty good bet that they'll finish——

General POLLOCK. Oh, yes, ma'am.

Senator MIKULSKI [continuing]. And stay.

General POLLOCK. Yes, ma'am.

Admiral BRUZEK-KOHLER. Uh-huh.

Senator MIKULSKI. Just one last thing. If, then, after they do that, are they still treated like a GS–5, or would they get an accelerated promotion?

General POLLOCK. No, they're treated like officers, and they begin as second lieutenants, the way that the other new graduate nurses are begun.

Admiral BRUZEK-KOHLER. And it's very interesting, when you talk with them. The transition is there, clearly. And the longer you've been an enlisted person, the more of a transition. But once you become a nurse and you're practicing in the field that you've wanted to practice for a very long time, they are a Navy nurse. What is important is that experience as an enlisted—previously enlisted person is what we use then to help teach our other enlisted people, "This is where I came from. This is what you can become." So, they become, again, a very good recruiting tool, as well as educator and mentor for our organization.

General RANK. Ma'am, the other things I would add is the debt repayment program. We love it in the Air Force Nurse Corps, because it's a graduated nurse who has a license in her hand, and she can go right to work immediately. So, we really love that program. And I'm looking at my statistic, that we have 25 percent males, and 24 percent of our enlisted corps is enlisted. So, I'll have to look at those two to see if it's predominantly a male force that came up through the enlisted ranks and now is in our nurse corps.

Senator MIKULSKI. Well, and, of course, then I hope that out of those that are already military nurses, we can think about how to help them become faculty, either in the academic sense of that word or in some way offer the clinical opportunities. And I'll bet it's going to be a bonanza for everybody.

So, let's work together on it, but I think we can make a difference. You already are making a difference. And thank you very much.

Senator INOUYE. This has been a very interesting discussion. And while listening to all of you, I couldn't help but recall that a few years ago we decided that cancer was a major scourge. And, as a result, the Government and the Congress established special subsidy programs for medical schools to set up cancer centers for special studies. Now, I think the time has come to declare that the nursing shortage is a national crisis. And, if that's the case, we can do a lot of things that you have suggested, with proper funding from the Congress of the United States. It's just as much an emergency as we find in anything else. So, I thank you very much for your contribution.

And, if I may, I'll use this for a personal note. Since April 1945, nurses have played important roles in my life. And I thank them for giving me the hope and the picture of the future, the good life.

And I'm certain there are thousands, if not millions, of others who have spent time in hospitals who feel the same way.

Admiral BRUZEK-KOHLER. Thank you, sir.

ADDITIONAL COMMITTEE QUESTIONS

Senator INOUYE. Well, thank you all for your testimony.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED TO LIEUTENANT GENERAL KEVIN C. KILEY

QUESTIONS SUBMITTED BY SENATOR TED STEVENS

Question. Have you modified the training you provide your Army medics and Navy Corpsmen and other military emergency care providers since hostilities began? What is your assessment of emergency care on the battlefield?

Answer. The Army Medical Department has changed the training of Army medics based on lessons learned from Operation Enduring Freedom and Operation Iraqi Freedom. We have incorporated these changes into the Army's Initial Combat Medic training at Fort Sam Houston, Texas and at new Medical Simulation Training Centers at major Army installations. We have also used these lessons to train deploying physicians, physician assistants and nurses.

Some examples of these changes including improving the medic's training in managing patients with hypothermia; the use of tourniquets and hemostatic agents as the primary means of controlling bleeding; the use of endotracheal intubation and nasopharyngeal airway for airway management; and training in medical support to detainee operations.

Feedback on the quality and effectiveness of battlefield emergency care from returning units is very positive. The statistics of battlefield mortality are the lowest in any previous conflict in which our country has been involved. The major causes of death on the battlefield have remained unchanged since the Civil War. These are: penetrating head trauma, massive torso trauma, blast trauma, hemorrhage from extremity wounds, tension pneumothorax, and airway difficulty. Of these injuries, Combat Medics significantly impact extremity hemorrhage, tension pneumothorax, and airway difficulty. Based on data from Vietnam and trauma data from Operation Iraqi Freedom/Operation Enduring Freedom, we employed new training methods that encompass the types of wounds and the danger of the combat environment.

In addition to Soldier Medic training, the Army's Self-Aid/Buddy-Aid skills training for every Soldier has also been revised, also focusing on the preventable causes of death on the battlefield. A new Combat Lifesaver Course incorporates many of the principles used in training Combat Medics. The combination of these training programs allows more medical skills to be available on the battlefield to save Soldiers' lives.

Question. How successful were you in meeting your mission recruiting goals for this past year? Are there any specialties that have seen a drastic decline in retention?

Answer. The Army Medical Department and United States Army Recruiting Command (USAREC) had varying degrees of success in meeting our recruiting goals for fiscal year 2005. We achieved 99 percent of our Medical Corps goal, 84 percent of our Dental Corps goal, 100 percent of our Medical Service Corps goal, 83 percent of our Army Nurse Corps goal, 110 percent of our Veterinary Corps and 151 percent of the Specialist Corps goal for individuals entering on to active duty. For the first time, we experienced difficulty in recruiting to 100 percent of our Health Professions Scholarship Program (HPSP) allocations. USAREC is working hard to ensure that this is not the start of a trend.

Retention of our fully trained force is a priority. While increases in incentives have helped, we still have retention challenges. Specifically, we are closely monitoring Anesthesiology, Pediatrics, Family Practice and Emergency Medicine. We have also seen a decline in Physician Assistants and all Nurse specialties.

Question. What are you as a service doing to try and address these critical shortfalls? How do you carry out the medical mission at home and abroad with a decline in recruiting and retention of specialty medical personnel?

Answer. The National Defense Authorization Act for Fiscal Year 2006 granted temporary Recruiting Incentives Authority for up to four new programs that should assist with the Army recruiting mission. One of these programs, the Recruiter In-

centive Pay (RIP), will provide monetary incentives for AMEDD recruiters to exceed their missions. RIP has been approved and is expected to begin in June 2006, after the mandated 45-day waiting period.

Another new program under review is the Officer Accession Bonus, which includes an additional monetary incentive for AMEDD applicants. This bonus would offer an immediate show of good faith and expedite the acceptance process. This program is expected to begin this summer or at the beginning of fiscal year 2007.

Additionally, we are pursuing a critical skills retention bonus for the physician assistants. We are pursuing incentive special pay for certain nurse specialties. We increased the incentive special pay for nurse anesthetists. We are increasing the nurse accession bonus for fiscal year 2007. We are exploring the increase of special pays for dentists. We utilize professional officer filler information system (PROFIS) personnel to fill shortages/vacancies within deploying units. The TRICARE network as well as temporary contracts are then used to meet the beneficiary mission.

Question. There is growing concern with how the Department monitors and addresses the emotional and mental health of each returning soldier, sailor, airman and Marine from combat. Can you each tell us how you are monitoring and treating those that are at risk for Post Traumatic Stress Disorder?

Answer. The Army Deputy Chief of Staff for Personnel (DCSPER) and the Army Surgeon General (TSG) share responsibility for the prevention and screening for Post Traumatic Stress Disorder (PTSD) for both active and reserve component Soldiers serving in the Global War on Terrorism (GWOT). The DCSPER is responsible for the Deployment Cycle Support Program (DCSP) aimed at Soldiers and family members and TSG has oversight of the Combat and Operational Stress Control (COSC) program aimed at Soldiers serving in GWOT. TSG also exercises command and control over behavioral health services at Army medical centers around the world providing treatment for Soldiers with PTSD.

During pre-deployment, the DCSP provides extensive training to Soldiers and family members on the operational and combat stressors and ways and means to lessen the impact of deployment and traumatic events. DCSP resources available to Soldiers include buddy aid, leadership support, chaplaincy services, primary care and behavioral health services. Family members are instructed on their roles, responsibilities and ways and means by which they may cope more effectively, support their deploying Soldier and seek and receive support and professional assistance. Soldiers are also introduced to COSC concepts and resources to prepare for combat and operational stress. Medical and behavioral health personnel are positioned in theater for forward prevention and care, to do assessments of unit and Soldiers' behavioral health needs, to teach techniques for prevention or reduction of acute stress reactions and to help conserve the fighting strength of the force by providing short term problem focused behavioral healthcare.

Prior to deployment Soldiers receive a pre-deployment assessment which includes a question about mental health. If Soldiers have a positive response to the mental health question, they receive a further evaluation by a clinician. The final recommendation is based on clinical judgment and commander input, which considers the geographical area in which the Soldier will be assigned and the potential environmental/austere conditions.

A face-to-face post-deployment health assessment (PDHA) by trained healthcare provider during the re-deployment process has been in place for several years aimed at identifying and referring Soldiers with PTSD symptoms needing professional assistance. Referrals of these Soldiers for behavioral healthcare have routinely taken place and early intervention to lessen the impact of traumatic experiences has been emphasized.

Beginning in 2006, all active and reserve component Soldiers are receiving a face-to-face post-deployment total health re-assessment (PDHRA) at three to six months post-redeployment. Specific questions on the PDHRA screening aim at measuring the presence and impact of PTSD symptoms. Behavioral healthcare providers will be utilized to further assess the needs of Soldiers and ensure care is offered. If following the re-assessment there are identified healthcare needs, Soldiers will be offered care through by military medical treatment facilities, by Department of Veterans Affairs' medical centers or VET centers, by private healthcare providers through TRICARE, or through community-based healthcare organizations established by the Army.

If a Soldier has post-traumatic stress disorder or other psychological difficulties, they will be further evaluated and treated using well-recognized treatment guidelines. These include psychotherapy and pharmacotherapy. They may be delivered in a variety of venues, to include in theater and garrison, an outpatient or inpatient setting, and individually or in a group.

Question. How do you determine when a service member who has been receiving treatment for PTSD is ready for deployment again? Are once-deployed soldiers, sailors, airmen and Marines being sent back too early?

Answer. The Army uses multiple screening processes to ensure all Soldiers who deploy are capable of performing their duties and do not pose a risk to themselves or other members of their unit.

Prior to deployment Soldiers receive a pre-deployment assessment which includes questions about mental health. If Soldiers have a positive response to the mental health questions they receive further evaluation by a clinician. If the Soldier has symptoms of PTSD on the pre-deployment assessment, the symptoms are evaluated and treated by a mental health practitioner. A fitness for duty assessment is ordered if necessary. The final recommendation on deployment is based on clinical judgment of the treating provider and input from the unit commander.

Research shows that all Soldiers are affected by combat experiences and the most seriously affected are those exposed to frequent direct combat or the injuries sustained in combat. It is likely that multiple deployments will lead to increased symptoms of PTSD. Soldiers with PTSD are identified in multiple ways. They may self-identify, be identified by the post-deployment health assessment, the post-deployment health re-assessment, or be referred by a family member or command. If a Soldier has PTSD or other psychological difficulties, they are further evaluated and treated using well-recognized treatment guidelines. These include psychotherapy and pharmacotherapy. They are delivered in a variety of venues, in theater and garrison, an outpatient or inpatient setting, and individually or in a group.

QUESTIONS SUBMITTED TO VICE ADMIRAL DONALD C. ARTHUR

QUESTIONS SUBMITTED BY SENATOR TED STEVENS

Question. Have you modified the training you provide your Army medics and Navy Corpsmen and other military emergency care providers since hostilities began?

Answer. Yes, the Navy has integrated emergency/trauma training throughout the educational continuum and in a variety of training centers. Please note the examples below:

Naval Hospital Corps School, Great Lakes, IL (NHCS).—This is the first school in the career of a Corpsman. Since 2002, many changes have been made in response to regular communication between Field Medical Service School (FMSS) and NHCS. A variety of lessons and content have been added to the Tactical Combat Casualty Care and Care of the Patient with exposure to Nuclear Explosives courses. The courses have transitioned from group-paced lectures into a 100 percent blended learning environment.

Independent Duty Corpsmen (IDC) Training at Naval School of Health Sciences (NSHS) San Diego, CA.—The IDC program has adjusted its curriculum to enhance the training for medical personnel who perform in an operational/remote environment, often without a medical officer. In the last two years students now attend the Operational and Emergency Medical Skills (OEMS) course which provides training to care for casualties using the principles taught in Advanced Trauma Life Support (ATLS) and addresses the mission of special medical care: prolonged transport times, unique military wounds and the pre-hospital environment. Additionally, the IDC program trauma unit has been revised to incorporate the principles/curriculum of TCCC.

Tactical Combat Casualty Care (TCCC).—Corpsmen and Medics are trained in TCCC in response to evidence based practice used on the battlefield. The USMC has published a Marine Corps Order that all 8404s will now receive TCCC training. The Naval Expeditionary Combat Command (NECC) has adopted the same requirements for their Corpsmen. To help support the NECC and USMC Individual Augmentee (IA) deployment TCCC training, the Naval Medical Education and Training Command (NMETC) has instructed the Naval Operational Medicine Institute (NOMI) to institute a TCCC "Train the Trainer" program. The first training sessions will take place the first week of June 2006 with multiple courses to follow.

Naval Expeditionary Medical Training Institute located at Camp Pendleton, CA (NEMTI).—NEMTI is instructing and updating Fleet Hospital (FH), Expeditionary Medical Facility (EMF) and Battle Skills standards based on requirement-driven training. These training standards are built upon several items: Subject Matter Expert Review, current AOR After Action Reports, Medical Lessons Learned and requirements based upon specific COCOMs, OPLANS, and AOR's. This is also aligned with the Naval Audit Report (2003).

Joint Special Operations Medical Training Center in Fort Bragg, NC (JSOMTC).—Curriculum changes were made to move the Combat Trauma Management module to the Special Operations Combat Medic (SOCM) course to provide the Army Rangers, 96th Civil Affairs Medics, SEAL Corpsman, Recon Corpsman, and Special Warfare Combat Crewman additional trauma training before going to their units. The total curriculum remains the same with minor changes to curriculum information and updates to support feedback and after action reports from the field. The length has remained the same; the frequency of the training has increased from four classes per year to eight beginning this fiscal year.

Marine Aircraft Wings (MAW) Training.—MAWs have instituted training of organic, Medical Augmentation Program (MAP) personnel and Individual Augmentees to serve as Casualty Evacuation Corpsmen. The training which includes trauma care, aviation physiology and aircraft orientation varies from 1–4 weeks. In addition Navy squadrons are augmenting the Army Air Ambulance Mission and have procured Search and Rescue (SAR) Corpsmen and provided them with 4 weeks of Army Flight Medic Training under the auspices of NAVAIRFOR.

Navy Trauma Training Course located at Los Angeles County-USC Medical Center, Los Angeles, CA (NTTC).—This entire program for Corpsmen, Nurses and Physicians was started in the summer of 2002 in support of the increased operational tempo and the need for trauma training. Traditionally Naval Medical Facilities did not treat a sufficient number of trauma cases to provide adequate initial and sustainment training to achieve proficiency. NTTC incorporates a military specific Pre Hospital Trauma Life Support (PHTLS) training for Corpsmen as part of their curriculum.

Question. What is your assessment of emergency care on the battlefield?

Answer. "Emergency care on the battlefield is much improved, so much so that the survival of our combat casualties is vastly better than it was in Viet Nam." This quote is from the Journal of Trauma, February 2006. (Holcomb JB, Stansbury LG, Champion HR, Wade C, Bellamy RF. Understanding combat casualty care statistics. J Trauma. 2006 Feb;60(2):397–401.)

COMPARISON OF STATISTICS FOR BATTLE CASUALTIES, 1941–2005

	World War II	Vietnam	OIF/OEF
Percent KIA	23.7	21.3	12.5

Question. How successful were you in meeting your mission recruiting goals for this past year? Are there any specialties that have seen a drastic decline in retention?

Answer. The Navy's Medical Department Recruiting did not meet recruiting goals in fiscal year 2005 for either the Active Component (AC) or Reserve Component (RC) and has had limited success this year to date. The Nurse Corps has been much more successful this year with its student programs and Direct Accessions thanks to the initiatives mentioned below. The Direct Accessions for the Medical Corps, Dental Corps and Medical Service Corps are falling short of the mission recruiting goal this year.

The following specialties have had an increased loss rate over the past few years:

Medical Corps—Preventive Medicine, Psychiatry, Family Medicine, and Occupational Medicine.

Dental Corps—Endodontics, Orthodontics, and Periodontics.

Medical Service Corps—Clinical Psychologists, Pharmacists, and Physician Assistants.

Nurse Corps—Family Nurse Practitioners.

Question. What are you as a service doing to try and address these critical shortfalls?

Answer. Efforts to increase recruitment and retention of qualified health care professionals in Navy Medicine are underway in several directions. This year, the compensation for Health Services Collegiate Program (HSCP) students (used by Dental Corps and Medical Service Corps) increased from E3 to E6 pay, greatly improving the success of that program. Increases in the Dental Officer Multiyear Retention Bonuses were also realized for fiscal year 2005.

The fiscal year 2006 NDAA recently authorized Incentive Special Pay (ISP) for Oral and Maxillofacial Surgeons.

Funding has recently been increased for the Health Professions Loan Repayment Program (HPLRP) which was authorized in 1998. This offers over $30,000 per year

to be paid directly toward loans incurred for healthcare training. This is used for both retention and recruitment across all medical communities.

Nurse Corps recruiting continues to be impacted by the national shortage of nurses, resulting in strong competition for a finite pool of work force nurses and nursing school students. The primary strategies chosen to recruit and retain our Nurse Corps officers include the following:

—The Nurse Corps Direct Accession Bonus was increased at two levels: $15,000 (incurring a 3 year obligation) and $20,000 (with a 4 year obligation).

—HPLRP was offered for the first time this year as both a recruiting and retention tool.

—The Nurse Candidate Program (NCP) accession bonus was increased from $5,000 to $10,000, and the monthly stipend increased from $500 to $1,000. In addition, NCP has been expanded by twenty openings this year.

Medical Service Corps' increases in HSCP compensation have improved interest. HPLRP awards were offered to an expanded number of clinical psychologists and podiatrists this year and are being used for accessions for the first time. One-year HSCP scholarships are being successfully used to recruit candidates already in training for some of the specialties.

Question. How do you carry out the medical mission at home and abroad with a decline in recruiting and retention of specialty medical personnel?

Answer. We have adopted several measures to respond to this challenging issue. One, we make every attempt to maximize the efficiency of our existing staff. This includes ensuring that our providers are focused on clinical rather than administrative services. Two, we focus the use of support and ancillary staff on the clinical mission. Third, where indicated, clinic hours have been adjusted to meet demand. Fourth, to address shortfalls and meet access standards, we engage in greater use of contract services and network referrals, while at the same time attempting to maintain training programs vital to operational medical readiness.

Question. How do you determine when a service member who has been receiving treatment for PTSD is ready for deployment again? Are once-deployed soldiers, sailors, airmen and Marines being sent back too early?

Answer. We employ numerous methods for screening those at risk for development of PTSD and related conditions. Service members are screened prior to deployment, upon redeployment, and again periodically after returning from deployment. At any point if a service member presents symptoms that indicate the potential need for treatment, he or she is referred to an appropriate mental health or medical provider for complete evaluation and any treatment deemed necessary.

Navy Medicine actively encourages Sailors and Marines to seek care for behavioral healthcare concerns from a variety of sources. Behavioral healthcare services are included on all deployment and redeployment briefs. Navy chaplains provide information on availability of counseling from pastoral and medical sources in Warrior Transition Briefs. Fleet and Family Service Centers and Marine Corps Community Services publish availability of non-medical counseling for behavioral issues.

If after treatment a service member's condition is not judged to have improved such that he or she can be returned to full duty, they are placed in a limited duty status to ensure that they get whatever further treatment is necessary. At this time, we have no evidence that service members are, in general, being returned to a deployed environment too early.

QUESTIONS SUBMITTED TO LIEUTENANT GENERAL GEORGE PEACH TAYLOR, JR.

QUESTIONS SUBMITTED BY SENATOR TED STEVENS

MEDICAL RECRUITING

Question. The Air Force plays a critical role in the medical evacuation of troops overseas. With recruiting and retention challenges, are you concerned that the Air Force will be unable to continue meeting the high optempo of meeting the needs of this mission overseas?

Answer. The Air Force Personnel Center (AFPC) places high priority on ensuring critical authorizations for aeromedical evacuation (AE) assignments are filled. Information from AFPC shows all AE authorizations are currently filled and they continually plan ahead to fill projected vacancies. At this time, AE is a voluntary career option. Multiple avenues exist to showcase AE as a positive career broadening opportunity for AF medics. Many AE forces reside in the Reserve Component, and they are actively engaged in recruiting and retention initiatives to ensure continued success in this vital Total Air Force mission.

POST TRAUMATIC STRESS DISORDER

Question. There is growing concern with how the Department monitors and addresses the emotional and mental health of each returning soldier, sailor, airman and Marine from combat. Can you each tell us how you are monitoring and treating those that are at risk for Post Traumatic Stress Disorder?

Answer. The Air Force views the monitoring and addressing of Post Traumatic Stress Disorder (PTSD) and all deployment related issues as a shared community responsibility not just a medical issue. In August 2005, the Air Force standardized this support by adding Chapter 8 Redeployment Support Process to Air Force Instruction 10–403, Deployment Planning and Execution. This instruction outlines the responsibilities of both commanders and helping agencies in supporting deployment members and their families.

Monitoring for PTSD begins with the post-deployment process. Thirty days before returning home, Airmen are given reintegration education by chaplain and mental health staff where reunion/reintegration issues are addressed, as well as mental health concerns that might occur and resources Airmen could pursue to address those concerns. Prior to returning home, the Area of Responsibility (AOR) commander is responsible for contacting the home station command for Airmen who could benefit from support due to personal loss, exposure to danger, or witnessing traumatic events.

As our troops re-deploy, post-deployment assessments are conducted for all Airmen, mainly in-theater, just before they return home, or within five days of re-deploying. Commanders ensure all re-deploying Airmen have completed their post-deployment medical processing immediately upon return from deployment, prior to release for downtime, leave, or demobilization. These are stored in electronic fashion and are available through TRICARE Online to our provider staffs worldwide.

During the post-deployment assessment, each Airman has a face-to-face assessment with a health care provider. This discussion includes discussion of any health concerns raised in the Post-Deployment Health Assessment questionnaire, mental health or psychosocial issues, special medications taken during the deployment, and concerns about possible environmental and occupational exposures. Concerns are addressed using the appropriate Department of Defense (DOD) guidelines such as the Veterans Administration (VA)/DOD Post-Deployment Health Clinical Practice Guidelines and the VA/DOD Clinical Practice Guidelines for Post-Traumatic Stress.

Within seven days of return to their home station, Airmen receive reintegration education by the installation helping agencies where issues that may develop are discussed and resources are identified. These briefings are mandatory for military members while family members are highly encouraged to attend.

To better ensure early identification and treatment of emerging deployment related concerns, at every medical appointment Airmen are asked if their appointment is deployment related.

Airmen complete another screening assessment, the Post-Deployment Health Re-Assessment (PDHRA), within three to six months of return from deployment. Appropriate referrals for care are made as indicated by their responses to the PDHRA questions.

In addition, on an annual basis, every military member receives a Preventive Health Assessment to ensure the required clinical preventive services are received and they meet their individual medical readiness requirements.

As evidenced above, early identification of PTSD and other deployment related concerns is accomplished by the active involvement of commanders and helping agencies who not only train themselves, but also the average Airman on how to recognize distress and match that distress with the appropriate resource. In 2004, the Air Force began to emphasize the concept of being a good Wingman, a person who actively assesses and responds to the needs of his or her fellow Airmen.

Air Force psychologists, psychiatrists, and social workers treat Airmen for PTSD at our Life Skills Support Centers (LSSC). Every installation in the Air Force has a LSSC and military members have first priority for treatment. The frequency and length of treatment is extremely variable, depending upon the symptom intensity, impact on functionality, and a host of other clinical issues.

RECRUITING GOALS

Question. How successful were you in meeting your mission recruiting goals for this past year? Are there any specialties that have seen a drastic decline in retention?

Answer. For fiscal year 2005, the Air Force Medical Service experienced limited success in recruitment of health professionals. The overall recruiting of fully qualified health professionals was 46.12 percent of goal (see chart 1). A fully qualified

health professional is a trained practitioner, fully ready to begin work and with no prior obligation to the Air Force.

CHART 1

Fully Qualified	Fiscal Year 2005 September 30, 2005		
	Req	Recruited	Req Percent
MC	204	29	14.22
DC	104	23	22.12
NC	350	.....	57.14
BSC	81	70	86.42
MSC	35	35	100.00
FQ Total	774	357	46.12

The Air Force Medical Service has been quite successful in recruiting of health care professionals through the Health Professions Scholarship Program (see chart 2). The Health Professions Scholarship and Financial Assistance Programs (HPSP/FAP) are valuable training and force sustainment pipelines, particularly for the Medical Corps and Dental Corps. The overall recruiting success for HPSP was 108.28 percent of goal while the resident Financial Assistance Program (FAP) met 56.41 percent of goal (see chart 3).

CHART 2

HPSP (Scholarships)	Req	Recruited	Req Percent
MC	191	220	115.18
DC	105	107	101.90
NC	7	3	42.86
BSC	23	23	100.00
MSC	.....	.....	.....
HPSP Total	326	353	108.28

CHART 3

FAP (Residents)	Req	Recruited	Req Percent
MC	35	21	60.00
DC	4	1	25.00
NC	.....	.....	.....
BSC	.....	.....	.....
MSC	.....	.....	.....
FAP Total	39	22	56.41

The Air Force Medical Service continues to struggle with retention and staffing of multiple required specialties. While retention rates have not declined dramatically in recent years, retention after completion of the initial active duty obligation remains low for many specialties.

RECRUITING AND RETENTION

Question. What are you as a service doing to try and address these critical shortfalls? How do you carry out the medical mission at home and abroad with a decline in recruiting and retention of specialty medical personnel?

Answer. The Air Force Medical Service (AFMS) continues to experience challenges in recruiting and retaining physicians, dentists and nurses. Our current monetary incentive strategy includes the Health Professions Scholarship Program (HPSP), accession bonuses, loan repayments, and special pays or bonuses for retention of required specialties. We are also addressing top non-monetary concerns affecting recruiting and retention, such as tour length, deployments, working conditions, and educational opportunities. The AFMS is working closely with Recruiting Service, the personnel community and the Secretary of the Air Force for Manpower and Reserve

Affairs to improve our accessions processes and secure the funding needed to retain health care professionals.

The AFMS optimizes the effectiveness of healthcare delivery via efficient management of well trained members and teams operating smaller, faster, mobile, and modular platforms. The AFMS carries out its medical mission by utilizing personnel resources based on their multiple skill sets and diverse training. Additionally, we develop mutually beneficial working relationships with our Sister Services, TRICARE affiliates and networks, and civilian contract providers.

POST TRAUMATIC STRESS DISORDER

Question. How do you determine when a service member who has been receiving treatment for PTSD is ready for deployment again? Are once-deployed soldiers, sailors, airmen and Marines being sent back too early?

Answer. The decision as to when an Airman who has been receiving treatment for Post-Traumatic Stress Disorder (PTSD) is ready for deployment is a medical decision made between the Airman and their medical provider based on medical expertise and the clinical circumstances. Command and mission constraints do not interfere with this medical decision making process. Airmen are not returned to deployable status before their medical provider has determined they are ready to deploy. Air Force psychiatrists, psychologists, and social workers are highly trained in the assessment and treatment of PTSD, as well as military fitness for duty determinations. These providers are trained in world-class residency and internship programs at medical centers across the United States.

Medical providers communicate medical fitness for duty to the personnel system through the use of medical profiles. Airmen receiving treatment for PTSD who the medical provider determines should not deploy are given a psychiatric S4 profile (nondeployable). Commanders cannot override the profile and Airmen cannot deploy until their medical provider changes this profile. Thus, the military cannot redeploy Airmen until their medical provider determines they are ready.

Factors that influence medical determinations of deployability include the resolution of the member's symptoms, the likelihood of relapse, the risk of recurrence if the member were re-exposed to trauma, the presence or absence of ongoing functional impairment due to the disorder, and the provider's estimation of the member's ability to psychologically tolerate the rigors of deploying to austere and hostile environments. If and when the provider determines the member is again ready for worldwide duty, the profile is changed from S4 to S1, S2, or S3 (all deployable profiles), depending on the clinical circumstances.

QUESTIONS SUBMITTED TO MAJOR GENERAL MELISSA A. RANK

QUESTIONS SUBMITTED BY SENATOR TED STEVENS

RECRUITING AND RETENTION

Question. How successful were you in meeting your mission recruiting goals for this past year? Are there any specialties that have seen a drastic decline in retention?

Answer. For fiscal year 2005, the Air Force Medical Service experienced limited success in recruitment of health professionals. The overall recruiting of fully qualified health professionals was 46.12 percent of goal (see chart 1). A fully qualified health professional is a trained practitioner, fully ready to begin work and with no prior obligation to the Air Force.

CHART 1

Fully Qualified	Fiscal Year 2005 September 30, 2005		
	Req	Recruited	Req Percent
MC	204	29	14.22
DC	104	23	22.12
NC	350	.....	57.14
BSC	81	70	86.42
MSC	35	35	100.00
FQ Total	774	357	46.12

The Air Force Medical Service has been quite successful in recruiting of healthcare professionals through the Health Professions Scholarship Program (see chart 2). The Health Professions Scholarship and Financial Assistance Programs (HPSP/FAP) are valuable training and force sustainment pipelines, particularly for the Medical Corps and Dental Corps. The overall recruiting success for HPSP was 108.28 percent of goal while the resident Financial Assistance Program (FAP) met 56.41 percent of goal (see chart 3).

CHART 2

HPSP (Scholarships)	Req	Recruited	Req Percent
MC	191	220	115.18
DC	105	107	101.90
NC	7	3	42.86
BSC	23	23	100.00
MSC	.....	.....	.....
HPSP Total	326	353	108.28

CHART 3

FAP (Residents)	Req	Recruited	Req Percent
MC	35	21	60.00
DC	4	1	25.00
NC	.....	.....	.....
BSC	.....	.....	.....
MSC	.....	.....	.....
FAP Total	39	22	56.41

The Air Force Medical Service continues to struggle with retention and staffing of multiple required specialties. While retention rates have not declined dramatically in recent years, retention after completion of the initial active duty obligation remains low for many specialties.

Question. What are you as a service doing to try and address these critical shortfalls? How do you to carry out the medical mission at home and abroad with a decline in recruiting and retention of specialty medical personnel?

Answer. The Air Force Medical Service (AFMS) continues to experience challenges in recruiting and retaining physicians, dentists and nurses. Our current monetary incentive strategy includes the Health Professions Scholarship Program (HPSP), accession bonuses, loan repayments, and special pays or bonuses for retention of required specialties. We are also addressing top non-monetary concerns affecting recruiting and retention, such as tour length, deployments, working conditions, and educational opportunities. The AFMS is working closely with Recruiting Service, the personnel community and our Secretary of the Air Force for Manpower and Reserve Affairs to improve our accessions processes and secure the funding needed to retain health care professionals.

The AFMS optimizes the effectiveness of healthcare delivery via efficient management of well trained members and teams operating smaller, faster, mobile, and modular platforms. The AFMS carries out its medical mission by utilizing personnel resources based on their multiple skill sets and diverse training. Additionally, we develop mutually beneficial working relationships with our Sister Services, TRICARE affiliates and networks, and civilian contract providers.

Question. How do you determine when a service member who has been receiving treatment for PTSD is ready for deployment again? Are once-deployed soldiers, sailors, airmen and Marines being sent back too early?

Answer. The decision as to when an Airman who has been receiving treatment for Post-Traumatic Stress Disorder (PTSD) is ready for deployment is a medical decision made between the Airman and their medical provider based on medical expertise and the clinical circumstances. Command and mission constraints do not interfere with this medical decision making process. Airmen are not returned to deployable status before their medical provider has determined they are ready to deploy. Air Force psychiatrists, psychologists, and social workers are highly trained in the assessment and treatment of PTSD, as well as military fitness for duty deter-

minations. These providers are trained in world-class residency and internship programs at medical centers across the United States.

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QUESTIONS SUBMITTED TO MAJOR GENERAL GALE S. POLLOCK

QUESTIONS SUBMITTED BY SENATOR TED STEVENS

Question. How successful were you in meeting your mission recruiting goals for this past year? Are there any specialties that have seen a drastic decline in retention?

Answer. Our efforts to achieve the Active Component nurse mission have not been successful since 1999. The U.S. Army Accessions Command (USAAC) achieved 83 percent of the required mission in fiscal year 2005. Unfortunately, USAAC projects that they will only complete 73 percent of mission in fiscal year 2006. As of April 30, 2006, the Active Component is 304 officers below authorized strength. Recruiting is essential as it is through new medical surgical nurse accessions that we then educate into specialties such as anesthesia, critical care, preoperative and OB/GYN nursing.

In fiscal year 2005, the recruiting mission for the Reserve component was 485, only 66 percent of this goal was achieved. Since 2003, accession into the Reserve is an average of 21 percent below mission. In addition, 50 percent of those nurses accessed are not baccalaureate prepared, and are not eligible to remain in the Reserves long-term.

Our active duty retention rate has declined overall to 91 percent in fiscal year 2005. Unfortunately, when we look at the number of specialty nurses, retention failure has lowered their numbers such that operational tempo is significantly increased and data indicates this increased deployment rate is contributing to their exit from the military. This is a problem for preoperative, critical care and emergency room nursing staff as well as the nurse anesthetists.

The Reserve Component retention rate is adversely affected by the failure to recruit BSN nurses and the mandatory release of those who are unwilling to complete their educational requirements to serve as a military officer.

Question. What are you as a service doing to try and address these critical shortfalls? How do you to carry out the medical mission at home and abroad with a decline in recruiting and retention of specialty medical personnel?

Answer. We are actively addressing both recruiting and retention to assess critical shortfalls. We recently implemented the "Every Nurse is a Recruiter" initiative to increase participation by all Army Nurses in nurse recruiting. Our AMEDD Enlisted Commissioning Program provides active duty Soldiers the opportunity to complete their BSN and receive an appointment as an Army Nurse. The Health Professions Loan Repayment Program is also available to our officers as both a recruiting and a retention incentive. Data suggests that retention of our officers is largely dependent on three main factors: job satisfaction, education and training, and retirement benefits. To better prepare our new graduates, we are developing an enhanced Nurse Internship Program. We also offer intense entry-level courses in a variety of nursing specialties and our nurse anesthesia program, ranked second in the nation, continues to serve us well. We fully fund many of our nurses to complete graduate or doctoral degrees in nursing or closely related fields. We recently implemented a pilot program to train Registered Nurse First Assistants. Finally, the U.S. Army Medical Command (MEDCOM) utilizes a system called the PROFIS Deployment System (PDS). The PDS helps to ensure equitability of deployments within each specialty of nursing by tracking both who has deployed and the duration of that deployment. All MEDCOM Soldiers are able to volunteer online for deployments, this on-

going opportunity provides an element of predictability for our officers. All of these programs are crucial to our accession and retention efforts.

We utilize a combination of Reserve Component, civilian and contract nurses to augment our deploying staff, but they are often not available. Our retention rate is negatively affected by the increased demand at home station for the nurses who are not deployed in support of OEF/OIF. Whenever we are unable to hire civilian nurses in part due to the hiring constraints of OPM on college graduate nurses or are unable to fill contract positions, our military nurses must serve in their stead in addition to normal work demands. This constant pressure on our junior nurses contributes to their decision to leave the military. Finally, data suggest that increased lengths of deployment negatively impact retention rates. In addition to increasing their incentive pay in fiscal year 2005, implementation of a 180-day deployment rotation policy was a good initial step in stemming the loss of our certified registered nurse anesthetists.

Question. How do you determine when a service member who has been receiving treatment for PTSD is ready for deployment again? Are once-deployed soldiers, sailors, airmen and Marines being sent back too early?

Answer. The Army uses multiple screening processes to ensure all Soldiers who deploy are capable of performing their duties and do not pose a risk to themselves or other members of their unit.

Prior to deployment Soldiers receive a pre-deployment assessment which includes questions about mental health. If Soldiers have a positive response to the mental health questions they receive further evaluation by a clinician. If the Soldier has symptoms of PTSD on the pre-deployment assessment, the symptoms are evaluated and treated by a mental health practitioner. A fitness for duty assessment is ordered if necessary. The final recommendation on deployment is based on clinical judgment of the treating provider and input from the unit commander.

Research shows that all Soldiers are affected by combat experiences and the most seriously affected are those exposed to frequent direct combat or the injuries sustained in combat. It is likely that multiple deployments will lead to increased symptoms of PTSD. Soldiers with PTSD are identified in multiple ways. They may self-identify, be identified by the post-deployment health assessment, the post-deployment health re-assessment, or be referred by a family member or command. If a Soldier has PTSD or other psychological difficulties, they are further evaluated and treated using well-recognized treatment guidelines. These include psychotherapy and pharmacotherapy. They are delivered in a variety of venues, in theater and garrison, an outpatient or inpatient setting, and individually or in a group.

QUESTIONS SUBMITTED TO REAR ADMIRAL CHRISTINE M. BRUZEK-KOHLER

QUESTIONS SUBMITTED BY SENATOR TED STEVENS

MEDICAL RECRUITING GOALS

Question. How successful were you in meeting your mission recruiting goals for this past year?

Answer. Navy did not meet recruiting goals in medical programs in fiscal year 2005 for either the Active Component (AC) or Reserve Component (RC). Navy attainment by program was: Medical Corps—58 percent AC, 60 percent RC; Dental Corps—76 percent AC, 39 percent RC; Medical Service Corps—82 percent AC, 60 percent RC; and Nurse Corps—73 percent AC, 97 percent RC.

Question. Are there any specialties that have seen a drastic decline in retention?

Answer. Within our wartime specialties, shortfalls have been identified in critical care—64 percent manned, peri-operative nursing—89 percent manned, and nurse anesthesia—90 percent manned.

ADDRESSING BILLET SHORTFALLS AND MEETING MISSION

Question. What are you as a service doing to try and address these critical shortfalls?

Answer. Navy is executing a Total Force plan to correct medical personnel shortages through a coordinated effort by the Chief of Naval Personnel, the Surgeon General of the Navy, Commander Navy Recruiting Command and Chief of the Navy Reserve.

We have reemphasized recruiting in critical medical specialties through an expanded bonus program, education loan relief programs, and medical specialty pays. Specific measures we have implemented since fiscal year 2005 include increasing capacity in our most popular accession programs, implementing the Health Profession

Loan Repayment Program, diversifying our accession sources, and increasing the following financial incentives: Nurse Corps Direct Accession Bonus, Nurse Candidate Program Accession Bonus, Nurse Candidate Program Monthly Stipend, and the Certified Registered Nurse Anesthesia Incentive Special Pay. We are continuously evaluating these newly initiated efforts while exploring other options to retain our talent at the 4–10 years of service level.

To combat reserve shortfalls, we have implemented a mobilization deferment process whereby an Active Component (AC) officer transitioning to the Reserve Component (RC) may apply for deferment from mobilization for up to one year. This initiative is aimed at those separating AC officers who have recently deployed and may be hesitant to transition to the RC for fear of immediate re-deployment. Additionally, we are considering an option for Medical Professionals that would permit shorter, predictable mobilization periods to limit "time away from practice," a common reason for both medical attrition and shortages in accession.

Question. How do you carry out the medical mission at home and abroad with a decline in recruiting and retention of specialty medical personnel?

Answer. Our facilities abroad have priority status and are not affected by medical manning shortfalls.

At home, we have a broad range of options, including contracting for care or referring care to the TRICARE Managed Care Support Contract Network. The TRICARE network is designed to support the military direct care system in times of sudden or major deployment of Military Treatment Facility staff. In addition, Reserve personnel in designated key specialties are utilized when required by Military Treatment Facilities at home.

POST TRAUMATIC STRESS RETURN TO DUTY

Question. How do you determine when a service member who has been receiving treatment for PTSD is ready for deployment again? Are once-deployed soldiers, sailors, airmen and Marines being sent back too early?

Answer. Anyone exposed to the extremely stressful environment of combat is affected by those events. The majority of service members are able to cope with and integrate these events over time and experience no significant or lasting impact. However, a small percentage will need assistance in dealing with their experiences and may ultimately be diagnosed and treated for PTSD or other mental health conditions.

Navy Medicine is committed to providing appropriate mental health care to our Sailors and Marines and to their families. In order to accomplish this mission several continuous programs of education, training, assessment, referral, and professional care have been implemented. These services are provided to service members and their families before, during, and after deployment to an operational theater.

For Sailors and Marines preparing for a deployment, the Department of the Navy (DON) provides a comprehensive program of stress education, health surveillance, and forward identification and management of stress symptoms, including psychiatric conditions such as PTSD. A broad range of services are available to our Sailors and Marines while underway and while in port via our MTFs, psychologists aboard ships, and other non-medical assets such as Fleet and Family Service Centers and chaplains. The Marine Corps' Combat Operational Stress Control (COSC) Office, headed by a Navy psychiatrist with combat experience, is actively engaged in heightening awareness of combat and operation stress, ensuring quick access to care, and strengthening the coping skills of Marines and their families. In theater, members with stress problems receive prompt support from chaplains, medical officers, and mental health providers embedded with the operating forces through the Operational Stress Control and Readiness (OSCAR) program. Upon returning, service members are prepared for reintegration with their communities through the "Warrior Transition" and "Return & Reunion" programs.

Navy Medicine actively encourages our Sailors and Marines to seek care for behavioral health concerns from a variety of sources. We include information on the availability of behavioral health care services on all deployment and redeployment briefs. Our Navy chaplains provide information on availability of counseling from pastoral and medical sources in Warrior Transition Briefs. Our Fleet and Family Services Centers and Marine Corps Community Services assets publish availability of non-medical counseling for behavioral issues.

The stigma associated with seeking mental health care remains a significant issue, both in the military and in society in general. To overcome that barrier, the Navy and Marine Corps team realizes that to overcome that barrier time and education are essential; however, at heart it is a leadership issue. As a result, we educate and indoctrinate our leaders to be aware of potential behavioral health care

concerns and of the availability of medical and non-medical assets to manage these concerns. Two new programs we offer are the "Leader's Guide to Personnel in Distress" with versions for both Navy and Marine Corps.

We continually evaluate service members prior to and immediately following their deployments to determine whether they've suffered any adverse psychological or physical consequences of that deployment using the Pre and Post Deployment Assessment (PDHA) process. Three to six months following deployment, we are instituting screening of each service member with the Post Deployment Health Reassessment (PDHRA). Any service member who identifies emotional or physical concerns related to their deployment is referred for further evaluation and treatment as indicated. If a service member is deemed to have a deployment limiting condition in need of treatment, we would not redeploy that member until appropriate treatment had been rendered and the service member restored to a duty status.

SUBCOMMITTEE RECESS

Senator INOUYE. The subcommittee will reconvene on May 10 at 10 a.m., in this room, SD–192, to review the missile defense program for fiscal year 2007.

The subcommittee will now stand in recess. Thank you very much.

[Whereupon, at 12:03 p.m., Wednesday, May 3, the subcommittee was recessed, to reconvene at 10 a.m., Wednesday, May 10.]